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	12/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/22/2022 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 a capacity of 34 and had a census of 28 at the time of this survey. Quality Review completed on 12/28/22	E 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.	
E 0034 SS=F Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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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	at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Administrator and Maintenance Supervisor on 12/22/22 at 11:30 a.m., the provided EPP communication plan did not address a means of providing information about the LTC facility's occupancy, needs, and its	E 0034	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected. The Evacuation Policy/Procedure was updated to include the means we use to provide information about our occupancy, needs and our ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee. A copy is Attachment "A." HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE	01/08/2023

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	ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of records review and during exit conference, the Administrator looked through the EPP and could not find a plan that addressed a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance.		AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. The policy/procedure was updated and is Attachment "A." WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: All nursing staff was educated regarding this update on 12/28/22. See Attachment "G" 4 pgs. All nurses will be educated as they hire on to assure compliance. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Director will conduct a table top exercise for nursing on a quarterly basis and bring the results to the quarterly QAPI meetings for evaluation. This will continue for a minimum of six months.	
E 0039 SS=C	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2),			

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Bldg. --	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. (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			

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	(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. (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			

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	(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 (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			

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	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 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			

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	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 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.			

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	*[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 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			

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	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. (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			

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	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 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			

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	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 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, including unannounced staff drills using the emergency procedures. The LTC 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	E 0039	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected.	01/08/2023

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	accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC 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 full-scale in a 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, 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 LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Supervisor on 12/22/22 at 11:40 a.m., documentation for the community-based exercise conducted on 12/08/22 and the additional exercise conducted on 11/03/22 were incomplete. Both exercises did not show if the facility's response was analyzed to ensure the EPP policies were effective. Based on interview at the time of records review and at the exit conference, the Administrator stated, no		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 Maintenance Supervisor has been re-educated regarding the need to follow up after any drill to do an after action report that includes analyzing how the facility responded, what was good and what needs to be improved. Attachment "B." That after action report will be included in the proof of the drill and will include the following: what was supposed to happen, what occurred, what went well, what the facility can do differently or improve upon and a plan with timelines for incorporating necessary improvements. (attachment "AA") WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: After every event the Maintenance Director will get with the Administrator to sign off on the drill and to assure that these after action items are included. HOW THE CORRECTIVE ACTION	

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	documentation for analyzing the LTC facility's response was completed.		WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: A Performance Improvement Plan has been completed for our quarterly QAPI meeting. The results of the drills will be discussed during the quarterly QAPI meetings to assure compliance. These results will continue for a minimum of six months and at least until 100% compliance is achieved after every drill.	
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 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.	

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	This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 34 and had a census of 28 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/28/22			
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 Based on observation and interview, the facility failed to ensure 1 of 4 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 5 residents and 5 staff. Findings include: Based on observation during an initial tour of the facility with the Maintenance Supervisor on 12/22/22 at 10:45 a.m and at 12:10 pm during the facility tour in the exit egress by utility room 4, there was a linen cart measuring 2 feet wide by 4 feet long against the wall obstructing travel to the	K 0211	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected. The Housekeeping Supervisor removed all of the items that were in the hallway. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE	01/08/2023

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	exit . Just around the corner by the private treatment room in the hall going to therapy there were 16 boxes of supplies stacked that obstructed the exit egress. Based on an interview at the time of observations, the Maintenance Supervisor stated that these items in the corridor would be removed. These findings were reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b)		AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents could be affected. The Housekeeping Supervisor and Maintenance Director will be responsible to remove all boxes left in the hallway as soon as they are delivered. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Director will do daily walk throughs to assure compliance. Attachment "C." HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of the walk throughs will be discussed during the quarterly QAPI meetings. This will continue for a minimum of six months and/or when 100% compliance has been achieved for at least six months.	
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure			

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	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 ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected.	01/11/2023

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	Based on observations during a tour of the facility with the Maintenance Supervisor on 12/22/22 from 12:05 p.m. to 1:30 pm. the linen room 3, central supply, supply room 1, laundry room, and oxygen storage room, are hazardous storage rooms that are greater than 50 square feet or are considered hazardous by code, were all equipped with a self-closing device on the door but did not immediately latch into the frame when tested. These doors used an electronic deadbolt that has a 10 to 30 second programmable delay. Based on interview at the time of observation, the Maintenance Supervisor agreed the rooms were used as storage, were larger than 50 square feet or are considered hazardous by code and stated the electronic deadbolt did not latch the door into the frame. These findings were reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		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. New door locks have been ordered and arrived on Jan 9, 23. All doors without immediate latching devices were changed changed on Jan 11, 23 to doors that latch immediately upon locking . Proof of order is Attachment "D." WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Director will check each door one time weekly to assure proper latching is completed. See Attachment "C" HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of these checks will be discussed during the quarterly QAPI meeting. This will continue for at least six months.	

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Supervisor on 12/22/2022 at 11:05 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted	K 0345	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected 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 company who does our inspections, Elwood Fire, has agreed to be responsible to perform a visual inspection of the fire alarm system twice yearly to assure compliance. The Maintenance Director has been re-educated regarding this matter - Attachment "D."	01/08/2023

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	on 10/10/22. Based on interview at the time of records review, the Maintenance Supervisor stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Director will be responsible to assure that this is completed every six months. An audit will be used to assure compliance - Attachment "C." HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Director will bring the results of the monitoring to the quarterly QAPI meetings to assure compliance. This will continue for a minimum of one year.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or			

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	combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 6 of 30 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 15 residents. Findings include: 1.Based on observation with the Maintenance	K 0363	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1. No residents were affected. The small wreath that was hanging on the residents door has been removed. She put it there to decorate for Christmas. She was	01/08/2023

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	Supervisor on 12/22/22 at 12:45 p.m., the corridor resident room door to room 129 was unable to fully close and latch because a wreath was hung on the door knob. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door would not close and latch unless the wreath was removed first. The wreath was removed at the time of observation. 2. Based on observation with the Maintenance Supervisor on 12/22/22 at 12:30 pm, the corridor door to the therapy kitchen was propped open with a chair. This impediment to closing the door was removed at the time of observation. This deficient practice could affect 5 residents and staff. 3.Based on observation with the Maintenance Supervisor on 12/22/22 from 12:05 pm to 1:30 pm the corridor doors to the therapy gym, therapy kitchen, maitenance office and the medicine room failed to immediately latch when closed due to the use of an electronic deadbolt that has a 10-30 second delay. These findings were reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		informed that she cannot put anything on her door knob. 2. No residents were affected. All staff was in-serviced on 12/28/22 regarding the regulation to not prop doors open. 3. The doorknob on the doors to the therapy gym, therapy kitchen, maintenance office and med room have been changed to have knobs that latch immediately. 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 Maintenance Director will do rounds 5 days weekly to assure nothing is left on a doorknob, no doors are propped open and the doorknobs on the specific rooms latch immediately. Attachment "C" The Maintenance Director was re=educated on this issue - See attachment "F." WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The rounds audit will be completed by the Maintenance Director 5 X's weekly	

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			HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of the rounds audit will be discussed during the quarterly QAPI meetings to assure compliance. This will continue for at least six months.	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 mechanical rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff and residents in the mechanical room area. Findings include:	K 0522	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE	01/08/2023

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	Based on observations during a tour of the facility with the Maintenance Supervisor on 12/22/22 at 12:25 p.m., the mechanical room had fuel-fired water heaters with a fresh air intake that was covered with lint and dirt. This condition does not allow for fresh air to completely enter the room. Based on an interview at the time of observation, the Maintenance Supervisor stated the intake was covered with lint and would need to be cleaned. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents could be affected. The intake in the Mechanical room that was dirty has been cleaned. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Cleaning of these vents and any other vents will be put on the preventative maintenance schedule to be completed by the Maintenance Director. See audit Attachment "C" HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of this cleaning will be discussed during the quarterly QAPI meeting. this will continue for at least six months.	
K 0753 SS=F Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled			

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	for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations 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 failed to ensure 17 of 19 corridor doors to resident rooms were covered with wrapping paper that covered 50-100 % of the door. LSC 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and 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 Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d).	K 0753	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All residents were affected. The decorative coverings on the doors (for Christmas) have been removed. 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. From this point on the doors will not have any decoration on them that covers more than 30% of the entire door. The Maintenance Director has been re-educated Attachment "E"	01/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 01 B. WING	12/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 28 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor on 12/22/22 from 12:05 pm to 1:30 pm., 17 of 19 resident room corridor doors were covered with wrapping paper decoration that covered from 50% to 100% of the doors. Based on interview at the time of the observation, the Maintenance Supervisor agreed the corridor doors were covered with a combustible decoration. These findings were reviewed with the Administrator and Maintnenance Supervisor at the exit conference. 3.1-19(b)		WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Director will do walk throughs 5 X's weekly to assure that there is nothing put on the doors that would be hazardous materials. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of this monitoring will be discussed during the quarterly QAPI meetings. This will continue for at least six months.	
K 0754 SS=E	NFPA 101 Soiled Linen and Trash Containers			

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	155839	A. BUILDING 01 B. WING	12/22/2022

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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Bldg. 01	Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where 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 failed to ensure trash receptacles in 1 of 4 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 20 residents in the front hall. Findings include: 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 within a 64 square feet area in the front hallway in the vicinity of room 120. Based on interview at the time of observation, the Maintenance Director stated there were two 20-gallon barrels of trash totaling 40 gallons on the front hallway. The finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference.	K 0754	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected. 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. All trash cans outside of rooms have been removed and replaced by small cans located inside	01/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 01 B. WING	12/22/2022

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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	3.1-19(b)		resident's rooms. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: During the daily walk throughs by the Maintenance Director, the placement of trash cans will be monitored to assure that none are outside of the rooms. See Attachment "C." HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of this monitoring will be discussed during the quarterly QAPI meeting. This will be ongoing for at least six months.	