STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE WEST	55 N MISSION DR, INDIANAPOLIS, , 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00458915, IN00459162, IN00462737, and IN00463445. Complaint IN00458915 - No deficiencies related to the allegations are cited. Complaint IN00459162 - No deficiencies related to the allegations are cited. Complaint IN00462737 - No deficiencies related to the allegations are cited. Complaint IN00463445 - No deficiencies related to the allegations are cited. Survey dates: July 23 and 24, 2025. Facility number: 011840 Residential Census: 34 These State Residential	R 0000		

	Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 4, 2025.			

R 0030	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(e)(1-6) (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on interview and record review, the facility failed to follow its policy to ensure a comprehensive admission agreement and lease procedure was executed to protect the	R 0030	Per IDOH-TAG R030 has been deleted	08/12/2025

	resident's rights as a Lessee, and the facility failed to allow the Resident's Power of Attorney (POA) opportunity to acknowledge, by signature, the full rights and responsibilities of the parties included in the lease contract for 1 of 3 residents reviewed for admission/transfer and discharge (Resident E). Findings include: During a confidential interview, it was indicated that Resident E had been sent to the hospital on 6/3/25 and had still not been permitted to return to his apartment because the facility wanted to ensure he was still capable of living at the Residential level and had not had an increase in his level of care. It was indicated Resident E had become a resident at the facility in August of 2024, but before he would move into his apartment, he needed to complete some therapy at a skilled facility first. In order to reserve his chosen apartment, Resident E was asked to complete a Lease and Service Agreement.			

	On 7/23/25 at 10:00 a.m. Resident E's record was reviewed. He had been a residential resident at the facility from 11/25/24 until 6/3/25 when he was transferred to the hospital for an acute change of condition. He had diagnoses which included, but were not limited to, dementia with agitation and behavioral outburst, bradycardia, and anemia. Resident E had a POA, dated 9/5/23, which superseded all documents below and indicated the POA had been granted, " ...general authority with respect to records, reports and statements ... general authority with respect to personal care management and specifically, the authority to take any steps necessary for maintaining my customary standard of living including assisting with operation of my household, providing personal and health care management for me whether that entails the provision of direct care or the hiring of others (including family members) to assist in my personal and health care management ..." Resident E had an initial Lease and Service Agreement which was signed and dated by Resident E on 8/29/24. The Lease was not signed by a			

	facility staff member. The Lease was not signed or acknowledged by the POA, and the record lacked documentation of an initial copy of the Lease and Service agreement had been provided to the POA for review on Resident E's behalf. The Lease and Service Agreement indicated, " ...Receipt of the first month's rent and service fee is hereby acknowledged by the lessor ... to maintain a referral process to assist with transition to an alternate setting should the contract be terminated, to include assistance provided the Lessee in locating a community/setting that provides a level of care as documented in state-approved assessment paperwork. This assistance may involve contacting social service agencies and disclosing information about the Lessee's health status and health care needs. The Lessee permits disclosure of the information necessary to comply with this paragraph. The Lessee must notify the Lessor in writing if he/she does not want this information to be disclosed. The record lacked documentation of a written statement from Resident E and/or his POA any wishes not to disclose certain health care information which may delay the			

admission/re-admission of the Resident.

During an interview on 7/24/25 at 12:00 p.m., the Cooperate Consultant indicated Resident E had been sent to the hospital on 6/3/25 after he was found down on his knees in his apartment and complained of severe pain. He went to the hospital to receive an evaluation and treatment, however, when it came time for him to return to his apartment, it was unclear whether or not he still met the minimum function level to remain at the Residential level. Upon request for further documentation to determine if he was appropriate to return, the POA only allowed redacted records, therefore the facility delayed determination. The Cooperate Consultant acknowledged the original Lease and Service Agreement had not been signed by a facility staff member and was not sure if a copy had been provided to the POA for review. The Cooperate Consultant indicated the Lease and Service Agreement was also considered the current facility policy.

This deficient practice is related to Complaint IN00463445.

Based on interview and record review, the facility failed to follow its policy to ensure a comprehensive admission

	agreement and lease procedure was executed to protect the resident's rights as a Lessee, and the facility failed to allow the Resident's Power of Attorney (POA) opportunity to acknowledge, by signature, the full rights and responsibilities of the parties included in the lease contract for 1 of 3 residents reviewed for admission/transfer and discharge (Resident E). Findings include: During a confidential interview, it was indicated that Resident E had been sent to the hospital on 6/3/25 and had still not been permitted to return to his apartment because the facility wanted to ensure he was still capable of living at the Residential level and had not had an increase in his level of care. It was indicated Resident E had become a resident at the facility in August of 2024, but before he would move into his apartment, he needed to complete some therapy at a skilled facility first. In order to reserve his chosen apartment, Resident E was asked to complete a Lease and Service Agreement. On 7/23/25 at 10:00 a.m. Resident E's record was reviewed. He had been a residential resident at the facility from 11/25/24 until 6/3/25 when he was transferred to the			

	hospital for an acute change of condition. He had diagnoses which included, but were not limited to, dementia with agitation and behavioral outburst, bradycardia, and anemia. Resident E had a POA, dated 9/5/23, which superseded all documents below and indicated the POA had been granted, " ...general authority with respect to records, reports and statements ... general authority with respect to personal care management and specifically, the authority to take any steps necessary for maintaining my customary standard of living including assisting with operation of my household, providing personal and health care management for me whether that entails the provision of direct care or the hiring of others (including family members) to assist in my personal and health care management ..." Resident E had an initial Lease and Service Agreement which was signed and dated by Resident E on 8/29/24. The Lease was not signed by a facility staff member. The Lease was not signed or acknowledged by the POA, and the record lacked documentation of an initial copy of the Lease and Service			

	agreement had been provided to the POA for review on Resident E's behalf. The Lease and Service Agreement indicated, " ...Receipt of the first month's rent and service fee is hereby acknowledged by the lessor ... to maintain a referral process to assist with transition to an alternate setting should the contract be terminated, to include assistance provided the Lessee in locating a community/setting that provides a level of care as documented in state-approved assessment paperwork. This assistance may involve contacting social service agencies and disclosing information about the Lessee's health status and health care needs. The Lessee permits disclosure of the information necessary to comply with this paragraph. The Lessee must notify the Lessor in writing if he/she does not want this information to be disclosed. The record lacked documentation of a written statement from Resident E and/or his POA any wishes not to disclose certain health care information which may delay the admission/re-admission of the Resident. During an interview on 7/24/25 at 12:00 p.m., the Cooperate Consultant indicated Resident E			

	had been sent to the hospital on 6/3/25 after he was found down on his knees in his apartment and complained of severe pain. He went to the hospital to receive an evaluation and treatment, however, when it came time for him to return to his apartment, it was unclear whether or not he still met the minimum function level to remain at the Residential level. Upon request for further documentation to determine if he was appropriate to return, the POA only allowed redacted records, therefore the facility delayed determination. The Cooperate Consultant acknowledged the original Lease and Service Agreement had not been signed by a facility staff member and was not sure if a copy had been provided to the POA for review. The Cooperate Consultant indicated the Lease and Service Agreement was also considered the current facility policy. This deficient practice is related to Complaint IN00463445.			
R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the following: (A) Resident name.	R 0302	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and	08/12/2025

	(B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observations and interview, the facility failed to store external medications from internal medications (topical creams and nasal sprays) separately, failed to label over the counter medications and date nasal sprays for 2 of 2 medication carts observed. Findings include: On 7/23/25 at 11:00 a.m., the second-floor medication cart was observed. There were multiple hydrocortisone creams stored with fluticasone nasal spray. The second-floor medication cart had a bottle of fluticasone nasal spray for Resident D with no date on it to indicate when it was opened. Resident 4 had a bottle of fluticasone nasal spray with no date to indicate when it was opened. Resident 5 had a bottle of melatonin 5 mg with no label on it. Resident 6 had a bottle of D3		submitted because of the requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. No residents were affected by this alleged deficient practice. The Nursing staff was immediately re-educated on the facility's policy for Pharmacy Services including Storing and labeling Drugs, with a special focus on Storing external medications from Internal medications (creams and nasal sprays). All medications have been audited to ensure appropriate labeling and dates opened present, as applicable. All residents have the potential to be affected. Nursing staff was re-educated on the facility's policy for Pharmacy Services: Storing and labeling Drugs, with a special focus on separating external medications from Internal medication including creams and nasal sprays and ensuring all over the counter medications have proper labels and open dates for nasal sprays. The facility's policy for Pharmacy services : Storing	

1000 units and acetaminophen 650 mg with no labels on the bottles.

On 7/23/25 at 1:00 p.m., the first-floor medication cart was observed. Lidocaine cream, hydrocortisone cream, and ammonium lactate lotion were being stored with Narcan (a nasal spray).

Resident 7 had a bottle of zinc tablets with no label on the bottle.

A policy titled, "Medication Expiration," was provided by the Administrator in Training (AIT) on 7/24/25 at 11:05a.m. It indicated, " ...Ophthalmic, otic, and nasal preparations will expire per the manufacturer expiration date unless, otherwise noted on manufacturer packaging ...."

A policy titled, "Drug labels," was provided by the AIT on 7/24/25 at 11:05 a.m. It indicated, " ...All drugs will be labeled in compliance with federal and state laws as well as standards of pharmacy practice ...."

Based on observations and interview, the facility failed to store external medications from internal medications (topical creams and nasal sprays) separately, failed to label over the counter medications and date nasal sprays for 2 of 2

Drugs, Drug Labels and over the counter medications were reviewed with no changes indicated. The DON and/or her designee will conduct rounds daily 5 x per week on scheduled work days x 4 weeks, 3 x per week x 4 weeks, weekly x 4 weeks then monthly thereafter to assure internal medications are stored separately from all other dosage forms intended for external use, all medications are properly labeled and all nasal sprays are labeled with open dates. Should concerns be identified, immediate corrective action shall be taken, and staff disciplined and/or re-educated as warranted.

As a means of quality assurance, the administrator will review any findings from the aforementioned monitoring ongoing and subsequent corrective actions taken. The monitoring will be increased or decreased, if indicated, to maintain compliance.

medication carts observed.

Findings include:

On 7/23/25 at 11:00 a.m., the second-floor medication cart was observed. There were multiple hydrocortisone creams stored with fluticasone nasal spray.

The second-floor medication cart had a bottle of fluticasone nasal spray for Resident D with no date on it to indicate when it was opened.

Resident 4 had a bottle of fluticasone nasal spray with no date to indicate when it was opened.

Resident 5 had a bottle of melatonin 5 mg with no label on it.

Resident 6 had a bottle of D3 1000 units and acetaminophen 650 mg with no labels on the bottles.

On 7/23/25 at 1:00 p.m., the first-floor medication cart was observed. Lidocaine cream, hydrocortisone cream, and ammonium lactate lotion were being stored with Narcan (a nasal spray).

Resident 7 had a bottle of zinc tablets with no label on the bottle.

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	Expiration," was provided by the Administrator in Training (AIT) on 7/24/25 at 11:05a.m. It indicated, " ...Ophthalmic, otic, and nasal preparations will expire per the manufacturer expiration date unless, otherwise noted on manufacturer packaging ...." A policy titled, "Drug labels," was provided by the AIT on 7/24/25 at 11:05 a.m. It indicated, " ...All drugs will be labeled in compliance with federal and state laws as well as standards of pharmacy practice ...."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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