CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				ON	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155159		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/09/2024	
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION				2940 N	ADDRESS, CITY, STATE, ZIP COD CLINTON ST VAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
E 0000							
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000			
E 0004 SS=C Bldg	City Nursing and R substantial complia Preparedness Requi Medicaid Participat CFR 483.73. The fa had a census of 43 a Quality Review cor 403.748(a), 416.5 441.184(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416 §441.184(a), §466 §483.73(a), §483. §485.68(a), §485.	200079 255159 266160  Preparedness survey, Summit ehabilitation was found in nee with Emergency trements for Medicare and ing Providers and Suppliers, 42 acility has a capacity of 93 and at the time of this survey.  Impleted on 01/11/24  4(a), 418.113(a), 5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),					
	The [facility] must Federal, State and	comply with all applicable					

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

preparedness requirements. The [facility]

TITLE (X6) DATE

Jae Gerardot Executive Director 01/30/2024

Any defiency statement 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155159		A. BUILDING B. WING		COMPLETED 01/09/2024				
	PROVIDER OR SUPPLIER	ND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805					
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	comprehensive er program that mee section. The emer program must include the following elem (a) Emergency Pladevelop and main preparedness plan and updated at lea must do all of the * [For hospitals at §485.625(a):] Emergency Planust develop and main preparedness required comprehensive er program that mee section, utilizing a * [For LTC Facilities Emergency Planust develop and main preparedness plan and updated at lease the section of th	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or app and maintain a mergency preparedness ts the requirements of this in all-hazards approach.  Ses at §483.73(a):]  The LTC facility must tain an emergency in that must be reviewed, ast annually.  Ities at §494.62(a):]  The ESRD facility must tain an emergency in that must be [evaluated], ast every 2 years.						
	failed to review and Preparedness Plan (	view and interview, the facility update the Emergency EPP) at least annually in CFR 483.73(a). This deficient	E 0004	E 004 SS=C – Develop EP p review and update annually What corrective action(s) w be accomplished for those				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155159		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/09/2024			
	ROVIDER OR SUPPLIER	ND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805				
	SUMMARY SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR practice could affect Findings include:  Based on records re Director on 01/09/2 administrator's copy 10/09/23 but the EP stations and mainter reviewed and updat on an interview dur. Maintenance Direct binders were not revelast year.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION It all occupants.  View with the Maintenance 4 at 10:41 a.m., the 7 of the EEP was reviewed on P binder from the two nurses' nance office were not ed within the last year. Based ing records review, the or confirmed 3 of 4 EPP viewed and updated within the viewed with the Maintenance		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)  residents found to have bee affected by the deficient practice. Maint Dire to be in serviced on updating EP binders yearly. How other residents having the potentito be affected by the same deficient practice will be identified and what correctivaction(s) will be taken. Staff residents have the risk of not having updated EP information available in ALL binders in case emergency. What measures be put into place and what systemic changes will be most to ensure that the deficient practice does not recur. Updated EP will be placed at nurse station and Modification in January/and as need they will be updated yearly down the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place; and by what date the systemic changes for each deficiency will be completed. ED will ensure the maintenance director updates binder. Maint Director to audit weekly X2 for 1 month then monthly for 12 months after the systemic place in the monthly for 12 months after the monthly for 12 months after the systemic place in the monthly for 12 months after the systemic place in the monthly for 12 months after the monthly for 12 months after the systemic place in the monthly for 12 months after the monthly for 12 months after the monthly for 12 months after the systemic place in the monthly for 12 months after the monthly	n  ctor All r ial  ve and on see of will ade elaint y. uring led. ) the  but elach at s EP t		
				ensure binder is in place and current. Date of Compliance1/26/2024			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155159		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 01/09/2024			
	PROVIDER OR SUPPLIER	ND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805					
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE		
E 0013 SS=C Bldg	403.748(b), 416.54 441.184(b), 482.15 484.102(b), 485.66 485.727(b), 485.96 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460 §483.73(b), §485.8 §485.68(b), §485.8 §494.62(b).  (b) Policies and pridevelop and implerparedness polition the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policibe reviewed and unique and procedures. The policibe reviewed and unique and procedures. The policibe reviewed and unique and procedures and procedures. The policibe reviewed and unique and procedures and procedures and procedures. The policibe reviewed and unique and procedures are policible and procedures and procedures and procedures. The policible reviewed and unique and procedure and procedu	4(b), 418.113(b), 5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b)  P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b), 6.360(b),						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155159		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2024		
	NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION		2940 N	ADDRESS, CITY, STATE, ZIP COD I CLINTON ST WAYNE, IN 46805	
(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	
	preparedness pol on the emergency (a) of this section paragraph (a)(1) communication polysection. The policiaddress manager nonmedical emer limited to: Fire; edilure; care-related disasters likely to safety of the parti. The policies and reviewed and upon the emergency (a) of this section paragraph (a)(1) communication polysection. The policies and years. These emenot limited to, fire failures, care-related supply interruption likely to occur in the area.  Based on record refailed to review and preparedness Plan at least annually in	ement emergency icies and procedures, based y plan set forth in paragraph in this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water end emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be lated at least every 2 years.  Ities at §494.62(b):] Policies The dialysis facility must ement emergency icies and procedures, based of plan set forth in paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are an at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are an equipment or power ted emergencies, water and natural disasters the facility's geographic view and interview, the facility di update the Emergency (EPP) Policies and Procedures accordance with 42 CFR icient practice could affect all	E 0013	E 013 SS=C – Develop of El Policies and Procedures What corrective action(s) wi be accomplished for those residents found to have been affected by the deficient practice.Maint Direct	III

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLET			ETED	
		155159	B. WING 01/09/2024			2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8	2940 N CLINTON ST				
SUMMIT	CITY NURSING A	ND REHABILITATION	FORT WAYNE, IN 46805				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					to be in serviced on updating i	All	
		eview with the Maintenance			EP binders policies and		
	Director on 01/09/2				procedures yearly. How other		
		y of the EEP Policies and			residents having the potential	al	
		viewed on 10/09/23 but the EPP			to be affected by the same		
		o nurses' stations and			deficient practice will be		
	maintenance office were not reviewed and				identified and what corrective		
	•	last year. Based on an			action(s) will be taken. Staff	and	
	_	cords review, the Maintenance			residents have the risk of not	,	
		3 of 4 EPP binders containing			having updated EP policy and		
		ocedures were not reviewed			procedure information availab	le in	
	and updated within the last year.				ALL binders in case of		
					emergency. What measures	WIII	
	This finding was reviewed with the Maintenance Director during the exit conference.				be put into place and what		
	Director during the	exit conference.			systemic changes will be ma	ide	
					to ensure that the deficient		
					practice does	_	
					not recur. Updated EP policie		
					and procedures will be placed nurse station and Maint Direct		
					will also retain a copy. This w be updated yearly during QAF		
					January/and as needed. <b>How</b>		
					corrective action(s) will be	uie	
					monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place; and by what date		
					the systemic changes for ea		
					deficiency will be		
					completed.ED will ensure that	t	
					maintenance director updates		
					policy and procedures EP bind		
					Manit Director to audit weekly		
					for 1 month then monthly for 1		
					months after to ensure binder		
					place and current.		
					Date of Compliance1/26/202	4	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155159		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 01/09/2024						
	PROVIDER OR SUPPLIEF	ND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805					
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
E 0029 SS=C Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §466 §483.73(c), §485. §485.68(c), §485. §485.920(c), §486 §494.62(c).  (c) The [facility] m an emergency preplan that complies local laws and mulat least every 2 years failed to review and Preparedness Plan (least annually in accupants.  Findings include:  Based on records replanding in concupants.  Findings include:  Based on records replanding include:	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 2.84(c), §482.15(c), 475(c), §484.102(c), 625(c), §485.727(c), 2.360(c), §491.12(c), 2.360(c), 2.	E 0029	E 029 SS=C – Development Communication Plan  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  Maint Director to be in service updating Communication Plan All EP binders, yearly.  How other residents having potential to be affected by the same deficient practice will I identified and what corrective action(s) will be taken.  Staff and residents have the contraction of the wing undated EP	n ed on n in the			

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	OF CORRECTION	IDENTIFICATION NUMBER  155159	A. BUILDING B. WING	onstruction 	COM	PLETED 9/2024	
	PROVIDER OR SUPPLIER CITY NURSING AN	ND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	This finding was red Director during the	viewed with the Maintenance exit conference.		Communication Plan ALL binders in case of emergency.			
				What measures will I place and what syste changes will be mad ensure that the defic practice does not recurred.  Updated Communica	emic e to ient cur.		
				be put in EP Binder w at nurse station and N will also retain a copy updated yearly during January/and as neede	vill be placed Maint Director This will be QAPI in		
				How the corrective a will be monitored to deficient practice wil recur, i.e., what quali assurance program into place; and by will the systemic change deficiency will be co	ensure the II not ity will be put hat date es for each		
				ED will ensure that medirector updates Complans in EP binders. In Director to audit week month then monthly for after to ensure binder and current.	munication Maint kly X2 for 1 or 12 months		
E 0036	403.748(d), 416.5	4(d), 418.113(d),		Date of Compliance 1/26/2024			
SS=C Bldg		5(d), 483.475(d), 483.73(d),					

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Facility ID: 000079

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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155159	B. WIN	NG		01/09/	/2024
NAME OF T	DROWNER OF GUIDNING		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C.		2940 N	CLINTON ST		
	CITY NURSING AN	ND REHABILITATION		FORT V	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		C LSC IDENTIFYING INFORMATION		TAG	DEFICIENC! )		DATE
	485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)						
	EP Training and T						
		6.54(d), §418.113(d),					
		0.84(d), §482.15(d),					
		475(d), §484.102(d),					
	. , , -	625(d), §485.727(d),					
		6.360(d), §491.12(d),					
	§494.62(d).	(-), 3 – (-),					
	3(-/.						
	*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184,						
	PACE at §460.84, Hospitals at §482.15,						
	HHAs at §484.102	2, CORFs at §485.68,					
	CAHs at §486.625	5, "Organizations" under					
	485.727, CMHCs	at §485.920, OPOs at					
	§486.360, and R⊦	IC/FHQs at §491.12:] (d)					
	Training and testir	ng. The [facility] must					
	develop and main	tain an emergency					
	preparedness trai	ning and testing program					
		ne emergency plan set forth					
	in paragraph (a) o						
		ragraph (a)(1) of this					
	<u> </u>	nd procedures at paragraph					
		and the communication					
	1	(c) of this section. The					
		g program must be					
	reviewed and upd	ated at least every 2 years.					
	*[For LTC facilities	s at §483.73(d):] (d) Training					
	and testing. The l	LTC facility must develop					
	and maintain an e	mergency preparedness					
	training and testin	g program that is based on					
	the emergency pla	an set forth in paragraph (a)					
	of this section, risk	k assessment at paragraph					
	(a)(1) of this section	on, policies and procedures					
		f this section, and the					
	communication plan at paragraph (c) of this						
	section. The train	ing and testing program					
	must be reviewed and updated at least						

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155159	B. WING 01/09/2024				
	PROVIDER OR SUPPLIER	ND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	annually.						
	testing. The ICF/II maintain an emergand testing prograemergency plans this section, risk a (a)(1) of this section at paragraph (b) ocommunication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i).	evacuation drills and training					
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the communic of this section. The orientation program updated at every 2	-					
	Based on record rev failed to review and Preparedness Plan ( annually in accorda This deficient practi Findings include:	view and interview, the facility lupdate the Emergency EPP) Training Program at least nee with 42 CFR 483.73(a). ice could affect all occupants.	E 0036	5	E 036 SS=C – EP Training ar Testing  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  Maint Director to be in service updating with Training and Tes	l 1 d on	01/26/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		155159	B. WING 01/09/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805				
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				the ne be re risk ining case nto		
				recur, i.e., what quality assurance program will be p into place; and by what date the systemic changes for ea deficiency will be completed ED will ensure that maintenan director updates Training and Testing in EP binders. Maint Director to audit weekly X2 fo month then monthly for 12 mo after to ensure binder is in pla and current.  Date of Compliance 1/26/2024	ch I. Ince onths		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155159	B. WI	NG		01/09/2024		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIE	R			CLINTON ST			
SUMMIT	CITY NURSING A	ND REHABILITATION			VAYNE, IN 46805			
		TELLIN BIELLIN (TION			1			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
K 0000								
Distr. 04								
Bldg. 01	A T 'C C C . C . 1	D (C ( 10)		000				
	-	e Recertification and State	K 0	000				
	_	was conducted by the Indiana						
	-	alth in accordance with 42 CFR						
	483.90(a).							
	Survey Date: 01/0	0/24						
	Survey Date. 01/0	9/24						
	Facility Number: 0	00079						
	Provider Number: 155159 AIM Number: 100266160							
	At this Life Safety	Code survey, Summit City						
		pilitation was found not in						
		equirements for Participation in						
	-	d, 42 CFR Subpart 483.90(a),						
		ire and the 2012 edition of the						
	-	ection Association (NFPA) 101,						
	Life Safety Code (1	LSC), Chapter 19, Existing						
	Health Care Occup	pancies and 410 IAC 16.2.						
	This two-story faci	ility with a basement was						
	determined to be or	f Type II (111) construction and						
	was fully sprinkler	ed. The facility has a fire alarm						
	system with smoke	e detection in the corridor, areas						
	open to the corrido	r and battery-operated smoke						
		ident rooms. The facility has a						
		cond floor and is fully						
		I EES 350 kW diesel powered						
	_	lity has a capacity of 93 and						
	had a census of 43	at the time of this survey.						
		e residents have customary						
		red. The facility does have a						
		ility services that was not						
	sprinklered.							
	Quality Review co	mpleted on 01/11/24						

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Event ID:

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPI A. BUILDIN	LE CONSTRUCTION  IG 01	(X3) DATE SURVEY COMPLETED
ANDTEAN	or conduction	155159	B. WING		01/09/2024
	PROVIDER OR SUPPLIER	ND REHABILITATION	294	EET ADDRESS, CITY, STATE, ZIP COD IO N CLINTON ST RT WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPRO	DBE COMPLETION
K 0223 SS=E Bldg. 01	enclosure, or horizor hazardous area and kept in the cloopen by a release 7.2.1.8.2 that autodoors throughout entire facility upon * Required manua * Local smoke det smoke passing the required smoke det * Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2. Based on observation failed to ensure 1 of to a hazardous area kept in the closed perelease device compute deficient practice compute failed to ensure 1 of to a hazardous area kept in the closed perelease device compute ficient practice ficient practi	osing Devices assageway, stairway contal exit, smoke barrier, a enclosure are self-closing used position, unless held device complying with matically closes all such the smoke compartment or activation of: I fire alarm system; and ectors designed to detect rough the opening or a etection system; and ler system, if installed; and  2.8, 19.2.2.2.7, 19.2.2.2.8 on and interview, the facility 2 laundry room corridor doors enclosure are self-closing and osition, unless held open by a oblying with 7.2.1.8.2. This ould affect staff in the  on with the Maintenance 4 at 12:10 p.m., the clean side for door was held open with a rview at the time of intenance Director agreed the with a device that did not alarm and removed the chair.	K 0223	K 0223 SS=E – Doors with Closing Devices  What corrective action(s be accomplished for those residents found to have the affected by the deficient practice.  Maint Director and Laund to be in serviced on not predoors open with a chair.  How other residents have the same deficient practice the same deficient practice be identified and what corrective action(s) will be taken.  Staff and residents have	s) will se been  try staff topping  ring ed by ce will

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155159	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/09/2024
	PROVIDER OR SUPPLIE	R ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP COI N CLINTON ST WAYNE, IN 46805	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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ULD BE PROPRIATE COMPLETION DATE
				of doors not properly clo case of emergency due propped open.	=
				What measures will be into place and what syschanges will be made to ensure that the deficien practice does not recur.  All chairs will be relocated from the doors to ensure not used as a prop.  How the corrective act will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will into place; and by what the systemic changes of deficiency will be composed open and to automatically the monitored open an	itemic ont ited away they are ion(s) sure the ot I be put i date for each oleted.  ve all or that was dit weekly inthly for is sure no
				1/26/2024	
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	construction 01	(X3) DATE SURVEY COMPLETED
		155159	B. WING		01/09/2024
	PROVIDER OR SUPPLIER	ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP COD N CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automatioption is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door.  Describe the floor hazardous areas to REMARKS.  19.3.2.1, 19.3.5.9	are protected by a fire our fire resistance rating rated doors) or an anguishing system in 8.7.1 or 19.3.5.9. When the sic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of that are deficient in			
	b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K32; Based on observation failed to ensure 1 of on the 100-hall with storage and greater	Fired Heater Rooms er than 100 square feet) nance, and Paint Shops froms (exceeding 64  In Rooms lons) frage Rooms/Spaces eet) classified as Severe (2) from and interview, the facility from 12 unoccupied resident rooms in large amounts of combustible than 50 square feet was dous area. This deficient	K 0321	K 321 SS=E – Hazardous  Areas- Enclosure  What corrective action(s) wide accomplished for those residents found to have been affected by the deficient practice Maint Directive Maint Directiv	n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155159	B. W	ING		01/09/	2024
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
OL IN AN ALT	OITY NILIDOING AN	ID DELLA DILITATIONI			CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION		FORT	WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'-	DATE
	Findings include:				will add a self-closure to room		
	, , ,				132. How other residents		
	Based on observation	on with Maintenance Director			having the potential to be		
		6 a.m., room 132 was being used			affected by the same deficier	nt I	
		d over 20 boxes of supplies,			practice will be identified and		
	_	square, therefore making the			what corrective action(s) will		
	_	eas. The room was not			be taken. Staff and residents		
		dous area because the			have the risk of doors not prop	erlv	
	-	room was not self-closing or			closing in case of emergency		
		Based on interview at the time			to the lack of self-closure on d		
	_	Maintenance Director agreed			of room 132. What measures		
		large amount of combustible			be put into place and what		
		than 50 square feet, and the			systemic changes will be ma	de	
	corridor door to the room was not self-closing.				to ensure that the deficient		
		5			practice does not recur.Roon	n I	
	This finding was re	viewed with the Maintenance			132 will have self-closure adde		
	Director during the				due to having supplies stored		
	8				being over 50quare feet. <b>How</b>		
	3.1-19(b)				corrective action(s) will be		
					monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place; and by what date		
					the systemic changes for each	ch	
					deficiency will be		
					completed.Maint Director add		
					closure to room 132 door and		
					audit weekly for 1 month and 1	or	
					x1 monthly for 12 months after		
					make sure closure remains int		
					Date of Compliance1/26/20		
K 0324	NFPA 101						
SS=E	Cooking Facilities						
Bldg. 01	Cooking Facilities						
5	Cooking equipmen	nt is protected in					
		IFPA 96, Standard for					
		I and Fire Protection of					
		ing Operations, unless:					
		ing operations, unitess.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	01	COMPLETED		
		155159 B. V		B. WING 01/0		
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		N CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION		WAYNE, IN 46805		
		THE REPUBLIE THE TOTAL		T		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ng equipment (i.e., small				
		as microwaves, hot plates,				
	· ·	d for food warming or limited				
	_	ance with 18.3.2.5.2,				
	19.3.2.5.2					
	_	open to the corridor in				
		ents with 30 or fewer				
		vith the conditions under				
	18.3.2.5.3, 19.3.2	.ວ.3, or s in smoke compartments				
		•				
		eatients comply with 18.3.2.5.4, 19.3.2.5.4.				
		protected according to				
	_	3 are not required to be				
	· ·	rdous areas, but shall not				
	be open to the co					
	· ·	n 18.3.2.5.4, 19.3.2.5.1				
	through 19.3.2.5.5					
		vation and interview, the	K 0324	K 324 SS=E - Cooking	01/26/2024	
		nintain 1 of 1 kitchens in	1 1 0 3 2 1	Facilities	01/20/2021	
		FPA 96, Standard for		What corrective action(s) w	ill	
		and Fire Protection of		be accomplished for those		
		ng Operations, 2011. NFPA 96,		residents found to have bee	n	
		ates all deep-fat fryers shall be		affected by the		
	installed with at lea	st a 16 inches space between		deficient practice.Maint Direct	ctor	
		e flames from adjacent cooking		will secure 2 baffles on the		
		12.1.2.5 states where a steel or		kitchen hood system. LA		
	tempered glass baff	fle plate is installed at a		electrical will also insure shute	off	
	minimum 8 inches	in height between the fryer and		will be added for the cook		
	surface flames of th	ne adjacent appliance, the		tops How other residents		
	requirement for a 1	6 inches space shall not apply.		having the potential to be		
	This deficient pract	ice could affect staff in the		affected by the same deficie	nt	
	kitchen.			practice will be identified an	d	
				what corrective action(s) wil		
	Findings include:			be taken. Staff and residents	are	
				at risk due to the kitchen hood		
		ration with the Maintenance		system not having secure baf		
		24 at 12:45 p.m., in the kitchen		x 2 and not having a shut off of	on	
		vas located 6 inches from the		cook tops in case of an		
	gas burners on the	commercial cooking stove and		emergency.What measures v	vill	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPL	ETED
		155159	B. WING 01/09/2024				
		100100				0 17 0 07	202 1
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP COD		
TOTAL OF I	NO VIDER OR SELLE			2940 N	CLINTON ST		
SUMMIT	CITY NURSING AI	ND REHABILITATION		FORT V	WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	did not have a prote	ective shield measuring at least			be put into place and what		
	eight inches in heig	tht between the two			systemic changes will be ma	de	
	appliances. Based	on interview at the time of			to ensure that the deficient		
	observation, the Ma	aintenance director agreed the			practice does not recur. The		
	fryer was less than	16 inches from an open flame.			kitchen hood system will have	2	
	-	-			baffles secured to it for proper		
					function and safety, as well as		
	#2) Based on obser	vation and interview, the			shutoff for the cook tops. <b>How</b>		
		intain 1 of 1 kitchens in			corrective action(s) will be	-	
		FPA 96, Standard for			monitored to ensure the		
		and Fire Protection of			deficient practice will not		
		ng Operations, 2011. NFPA 96,			recur, i.e., what quality		
		listed grease filters, listed			assurance program will be p	ut	
		ted grease removal devices for			into place; and by what date		
		al cooking equipment shall be			the systemic changes for each	:h	
		cient practice could affect staff			deficiency will be	<b></b>	
	in the kitchen.	prusuus sausuu urraan suurr			completed.Maint Director will	add	
	in the kitchen.				2 baffles to the kitchen hood	auu	
	Findings include:				system and shut off for cook to	20	
	i manigs metade.				and check weekly x2 for 1 mo	-	
	Based on an observ	ration with the Maintenance			then x1 monthly for 12 months		
		24 at 12:45 p.m., in the kitchen,			after to make sure baffles are	•	
		as missing two baffles. Based			secured to the kitchen hood		
	-	time of observation, the					
		tor found the baffles and tried			system. Date of		
		, but the baffles would not stay			Compliance1/26/2024		
	•	aintenance Director stated the					
	baffles will need to	be repaid.					
	#3 ) Raced on obcer	rvation and interview, the					
		sure staff had access to the					
	-	of 3 cook tops in the therapy					
		4 states within a smoke					
		ential or commercial cooking					
	•	sed to prepare meals for 30 or					
		be permitted, provided that					
		complies with all of the					
	following condition						
		ining the cooking equipment					
	is not a sleeping roo	om.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155159	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  01/09/2024				ETED
		155159	D. WIN	_		01/09/	2024
	PROVIDER OR SUPPLIER	ND REHABILITATION		2940 N	ADDRESS, CITY, STATE, ZIP COD CLINTON ST VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ining the cooking equipment					
	_	rom the corridor by partitions					
		3.6.2 through 19.3.6.5. ts of 19.3.2.5.3(1) through (10)					
	and (13) are met.	ts 01 17.5.2.5.5(1) through (10)					
	` ′	A switch meeting all of the					
	following is provide						
		, or a switch located in a					
		is provided within the cooking					
	1	ates the cooktop or range.					
	1 1	ed to deactivate the cooktop the kitchen is not under staff					
	supervision.	the Richell is not under starr					
	_	ice could affect five residents					
	in the therapy gym	and staff in the conference					
	room.						
	Findings include:						
	Based on observation	on with the Maintenance					
	Director on 01/09/2	4 at 11:14 a.m., there was a					
	_	py gym and in conference					
	_	rated from the corridor, but the					
	_	s were connected to power					
		e way to deactivate the er. Based on interview at the					
		er. Based on interview at the , the Maintenance Director					
		ps were not in use, still					
		, and stated there was not a					
	shutoff for the two	cooktops.					
		reviewed with the Maintenance					
	Director during the	exit conference.					
	3.1-19(b)						
K 0353	NFPA 101						
SS=E	Sprinkler System	- Maintenance and Testing					
Bldg. 01	1 .	- Maintenance and Testing					
	Automatic sprinkle	er and standpipe systems					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155159	B. Wl	NG		01/09	/2024
		1		STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		2940 N	CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION		FORT \	WAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	sted, and maintained in NFPA 25, Standard for the					
		ng, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
	1	sting are maintained in a					
		nd readily available.					
		r system last checked					
	, '	•					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMA	RKS information on					
	coverage for any	non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25					
	Based on observati	on and interview, the facility	K 0	353	K353 SS=E - Sprinkler Syste	<u>em</u>	01/26/2024
		he ceiling construction of 1 of 1			– Maintenance and Testing		
		of 1 vent unit mechanical room.					
		up hot air and gases around the					
	_	the sprinkler to operate at a			What corrective action(s) w	i <b>II</b>	
		ire. NFPA 13, 2010 edition,			be accomplished for those		
		distance between the sprinkler			residents found to have bee	n	
		eiling above shall be selected			affected by the		
		of sprinkler and the type of			deficient practice.		
		deficient practice affects 10			Moint Director will replace	ooina	
	residents on the ver	nt unit.			Maint Director will replace mi	_	
	Findings include:				ceiling tile in breakroom and r		
	i manigs metade.				hatch will be unexposed to rool latter access.	JI VIA	
	Based on observati	ons during a tour of the facility			latter decess.		
		ace Director on 01/09/24 at 1:50			How other residents having		
	p.m., the following				the potential to be affected by		
	-	om suspended ceiling there was			the same deficient practice v	_	
		ng exposing the ceiling about			be identified and what		
	two feet above the				corrective action(s) will be		
		cal room on the vent unit the			taken.		
	ladder access to the	e roof was exposed to the roof					
		et above the suspended			Staff and residents are at ris	k	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155159	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/09/2024
	PROVIDER OR SUPPLIE	R ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP COD I CLINTON ST WAYNE, IN 46805	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	sprinklers installed Based on interview observations, the M	Maintenance Director agreed		due to missing ceiling tile in breakroom and roof hatch that exposed the roof via latter acc.  What measures will be put	
	ceiling above the d	eviewed with the Maintenance		into place and what systemi changes will be made to ensure that the deficient practice does not recur.	С
	3.1-19(b)			Maint Director will replace mi ceiling tile in breakroom and r hatch will be unexposed to ro latter access.	roof
				How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and by what date the systemic changes for eadeficiency will be completed	the out ch
				Maint Director will replace miceiling tile in breakroom and replace will be unexposed to roughter access. This will be auditor 1 month x1 weekly then x1 monthly for 12 months after to make sure baffles are secured the kitchen hood system and cook top shutoffs are in place	oof of via lited d d d to
				Date of Compliance	

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	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155159	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  01/09/2024
	PROVIDER OR SUPPLIE	R ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP COD I CLINTON ST WAYNE, IN 46805	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	shall include not be provisions:  (1) Smoking shall ward, or compart liquids, combustil used or stored are location, and such signs that read N posted with the irresponsible shall prominently places secondary signs smoking shall not (3) Smoking by presponsible shall (4) The requirement apply where the property supervision.  (5) Ashtrays of not safe design shall where smoking is (6) Metal contained devices into which shall be readily as smoking is permit 18.7.4, 19.7.4  Based on observation failed to ensure stall and maintained the	ions ons shall be adopted and ess than the following  be prohibited in any room, ment where flammable ole gases, or oxygen is id in any other hazardous in area shall be posted with O SMOKING or shall be iternational symbol for no occupancies where ided and signs are id at all major entrances, with language that prohibits is be required. attents classified as not be prohibited. ent of 18.7.4(3) shall not oatient is under direct oncombustible material and be provided in all areas permitted. ers with self-closing cover in ashtrays can be emptied vailable to all areas where	K 0741	K741 SS=E – Smoking Regulations	01/26/2024
	container with self	-closing cover devices. This ould affect staff and 30		What corrective action(s) wi be accomplished for those	II

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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  D. WING	COMPLETED
155159 B. WING	01/09/2024
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD	
2940 N CLINTON ST	
SUMMIT CITY NURSING AND REHABILITATION FORT WAYNE, IN 46805	
(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 APPROPER DEFICIENCY)  TAG: PREGII A TORY OF LSC IDENTIFYING INFORMATION  TAG: PREGII A TORY OF LSC IDENTIFYING INFORMATION  TAG: PREGII A TORY OF LSC IDENTIFYING INFORMATION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG DEFICIENCY  residents using the front entrance.  residents found to have be	DATE
affected by the	en
Findings include: deficient practice.	
Based on observation with the Maintenance Maint Director will Inservice	all
Director on 01/09/24 between 9:00 a.m. and 2:00 smokers to smoke in designation	
p.m., outside of the exit dock area, a staff member smoking area and clean up of	
was observed smoking in a non-smoking area, butts found around facility.	-
also there were over 30 cigarette butts disposed	
on the ground around the dock and 30 cigarette  How other residents havin	_
butts in the vent pit by the front entrance. Based on interview at the time of observations, the the same deficient practice	
on interview at the time of observations, the  Maintenance Director agree there were cigarette  the same deficient practice be identified and what	WIII
butts on the ground and the staff smoking area  corrective action(s) will be	
was in the gazebo at the edge of the parking lot taken.	
and not at the docks.	
Staff and residents are at ri	
This finding was reviewed with the Maintenance an emergency due to staff no	
Director during the exit conference.  smoking in the approved are	ea.
3.1-19(b) What measures will be put	:
into place and what system	nic
changes will be made to	
ensure that the deficient practice does not recur.	
practice does not recur.	
Maint Director will educate	
smokers to smoke in the fac	ility
smoking area "gazebo" for s	· .
and pick up cig butts around	the
facility.	
How the corrective action(	s)
will be monitored to ensure	•
deficient practice will not	
recur, i.e., what quality	
assurance program will be	
into place; and by what dat	
the systemic changes for e	

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Event ID:

4LBX21

Facility ID: 000079

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155159	(X2) MUL A. BUIL B. WINC	DING	nstruction  01	(X3) DATE : COMPL 01/09/	ETED
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION				2940 N	DDRESS, CITY, STATE, ZIP COD CLINTON ST VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					Maint Director will educate state on smoking location and pick using butts found on facility proper This will be audited for X5 a wifer month, then x2 monthly for months to ensure staff smoke approved areas and are not placing cigs on the ground.  1/26/2024	ip erty. eek 12	

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