STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING -- B. WING	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT 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 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: 01/05/23 Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160 At this Emergency Preparedness survey, Summit City Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 93 and had a census of 44 at the time of this survey. Quality Review completed on 01/09/23	E 0000		
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: 01/05/23 Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160 At this Life Safety Code survey, Summit City Nursing and Rehabilitation was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gerardot Jae	ED	01/23/2023

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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	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. This two-story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to the corridor and battery-operated smoke detectors in the resident rooms. The facility has a vent unit on the second floor and is fully protected by Type I EES 350 kW diesel powered generator. The facility has a capacity of 93 and had a census of 44 at the time of this survey. All areas where the residents have customary access are sprinklered. The facility does have a shed providing facility services that was not sprinklered. Quality Review completed on 01/09/23			
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 2 cooler/freezer doors in the kitchen were able to open from the inside if locked and maintain 1 of 7 exit discharges doors were free of impediments to full instant use in the case of	K 0211	**K0211- Discharge Doors free of impediments to full instant use in the case of emergency.**	01/13/2023

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	fire or other emergency. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 states door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could staff in the kitchen and 20 residents on the 200 Long Hall. Findings include: Based on observation with the Environmental Services Director and the Administrator on 01/05/23 between 11:00 a.m. and 12:00 pm, the following was observed: #1.) The walk-in freezer had a door that could be locked with a key from the outside and had a turn release handle on the inside to open the door if lock. When tested, the release on the freezer door did not work by releasing the mechanisms that keeps the doors locked. This condition could trap a person inside the cooler or freezer if locked from the outside. Based on interview at the time of observation, the Environmental Services Director agreed the freezer release handle was not working and stated the release mechanism would need to be repaired. #2. The 200 long hall bottom stair exit door was equipped with panic hardware, but the door would not open on the first try. It took the Administrator excessive force to open the door. Based on interview at the time of observation, the Administrator agreed it took excessive force to open the exit door.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** - *Kitchen freezer door was de-iced and returned to working condition. exit door 1 of 7 has work order sent in to IEI for repair and correction.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - *Staff and residents have the risk of not being able to have freely access to exit doors in case of emergency.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** - Freezer door to be fixed and free from ice build up and exit door be repaired for freely opening in the case of emergency **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	The findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		**recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** *ED will ensure that new maintenance director checks freezer for free moving door as well as exit door, weekly for 4 weeks, then 1x week for 12 months.* **Date of Compliance** **1/13/2023**	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on all shifts for 4 of 4 quarters. This deficient practice could affect	K 0712	**K0712- Quarterly/monthly fire drills being completed at unexpected times**	01/13/2023

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	all residents, staff and visitors in the facility. Findings include: Based on records review with the Adminstrator on 01/05/23 at 9:31 a.m., the following shifts did not have fire drills at unexpected times: a. All first shift (6:00 a.m. to 2:00 p.m.) fire drills took place around 10:00 a.m. b. All second shift (2:00 p.m. to 10:00 p.m.) fire drills took place around 3:00 p.m. c. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place around 5:00 a.m. Based on interview at the time of record review, the Adminstrator agreed fire drills for all three shifts were not held at unexpected times. The findings were reviewed with the Administrator during the exit conference. 3.1-19(b) 3.1-51(c)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** - *New Maint Director to be in serviced on competing unexpected fire drills Quarterly/monthly* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - *Staff and residents have the risk of not having unexpected drills for education in case of emergency.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** - The fire drills will be completed at unexpected times moving fwd. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place; and by what date the systemic changes for each deficiency will be completed. *ED will ensure that new maintenance director does unexpected fire drills x3 monthly for 12 weeks, then 1x monthly for 9 months.* **Date of Compliance** **1/13/2023**	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers 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			

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	Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 1 basement corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff in the basement. Findings include: Based on observations with the Environmental Services Director on 01/05/23 at 11:11 a.m., there were over ten 33-gallon soiled linen/trash barrels side by side outside the launder room in the basement corridor. Based on interview at the time of observation, the Environmental Services Director stated the barrels are empty, but they are filled overnight and left in the corridor. The finding was reviewed with the Administrator and during the exit conference. 3.1-19(b)	K 0754	**K0754- Failed to ensure trash receptacles are out of corridor.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** - *New Maint Director/Laundry Supervisor to be in serviced on ensuring barrels are locked in the laundry room and not in corridor while not in use.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** - *Staff have the potential to not move freely in the hallways in case of emergency.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** - Barrels to be out of the corridor when not in use. **How the corrective action(s) will be monitored to ensure the**	01/13/2023

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. *ED will ensure that new maintenance director laundry Supervisor check for barrels to be our of corridor x1 daily for 30 days, then x1 monthly for 6 months.* **Date of Compliance** **1/13/2023**	
K 0761 SS=C Bldg. 01	Based on records review and interview, the facility failed to maintain complete documentation for the annual inspection and testing of 7 of 7 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other	K 0761	**K0761- Failed to ensure detailed inspection of fire doors where completed on 7 of 7 fire doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** - *New Maint Director/Laundry Supervisor to be in serviced on detailed checklist is used for inspection of 7 of 7 fire doors.*	01/13/2023

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	Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include:		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** - *Staff/residents have the potential to not have proper barriers inspected in case of emergency.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** - Detailed inspection of fire doors will be completed . **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** *ED will ensure that new maintenance director/ laundry Supervisor complete detailed fire door check list for 7 of 7 doors then ensure this is completed annually. ED to check x1 monthly for 6 months that detailed*	

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	Based on record review with the Administrator on 01/05/23 at 10:19 a.m., the TELS Computer documentation had a completion date of 7/30/22 for the annual fire door inspection but there was no itemized list for each door identifying items 1 through 11 listed above. Based on interview at the time of records review, the Administrator stated the annual fire door inspection was completed but there was no itemized list for each door . The findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		*inspection was completed.* **Date of Compliance** **1/13/2023**	