STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/09/2022

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

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: 12/9/22 Facility number: 011840 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 5, 2023.	R 0000		
R 0035 Bldg. 00	410 IAC 16.2-5-1.2(j)(1-7) Residents' Rights - Deficiency (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals. (3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Harris	Administrator	01/16/2023

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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	a pet of his or her choice shall be clearly stated in the admission agreement. (4) Refuse any treatment or service, including medication. (5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility. (6) Be afforded confidentiality of treatment. (7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities. Based on observation, interview and record review, the facility failed to allow residents to have the choice of a pet and to inform residents in the admission agreement that pets were not allowed to reside in the facility. This deficient practice had the potential to effect 34 of 34 residents who resided in the facility. Findings include: On 12/9/22 at 9:15 a.m., during the initial tour of the facility no pets were observed, in resident apartments, hallways, or outdoors on the grounds. A large wooden bird cage, in the hallway on the first floor, was clean and empty. On 12/9/22 at 11:18 a.m., during an interview, the Administrator indicated they did not allow any pets to reside in the building. Pets were allowed to visit with family members, but they could not live with the resident. They no longer had birds because the company (that provided the service) was not caring for them properly, so they had them removed. On 12/9/22 at 11:30 a.m., the current "Pet Policy,"	R 0035	**R 035** I. The facility has a pet policy in place as stated in the 2567 and shall ensure the policy is included in the admission agreement. II. In an effort to identify any residents who might be affected, the Administrator shall address current residents regarding the policy which indicates individual consideration such as size of the pet, ability of the resident to maintain the pet in a safe/sanitary environment, potential nuisance to other residents, and ability of the resident to feed and care for the pet on a daily basis. This policy shall also be clarified with facility staff, and the policy language shall be inserted in the admission agreement. III. Measures to ensure the deficient practice does not recur include the Administrator shall be	01/19/2023

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	was provided by the Administrator. This undated policy indicated "...Any pet housed in the facility shall have periodic veterinary examinations...Should a resident desire to retain a private pet within his or her apartment , the same must be discussed with facility administration. It is at the discretion of administration as the whether [sic] the housing of a personal pet is acceptable based on consideration such as: size of the pet, ability of the resident to maintain the pet in a safe/sanitary environment, potential nuisance to other residents, and ability of the resident to feed and care for the pet on a daily basis ...." During an interview on 12/9/22 at 3:37 p.m., the Director of Nursing (DON) indicated pets were under the discretion of the administration. The administration made the decision not to allow pets to reside in the building due to them tearing things up and residents not taking proper care of them in the past. The pet policy indicated it was at the administration's discretion and that was being enforced. It was not in the admission agreement. On 12/9/22 at 9:30 a.m., the resident admission agreement was provided by the Administrator. The admission agreement did not indicate the facility was pet free.		responsible to meet with any resident who desires to have a pet. Written record of the request and review of the considerations above shall be maintained with written determination of whether the pet was deemed appropriate to be on-site and be cared for by the resident, or if the request was denied, listing the explanation supporting the decision. IV. The corrective action will be monitored ongoing, as the Administrator shall be responsible to contact the Regional Director with each request and review the discussion of considerations and subsequent determination. Written record of the request and review shall be available upon request of the resident, representative or Regional Director to confirm ongoing compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the kitchen manager failed to wear a beard cover in the kitchen prep area for 1 of 1	R 0273	**R 273** I. The Kitchen Manager was addressed and re-educated	01/19/2023

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	observation. This deficient practice had the potential to effect 34 of 34 residents who resided in the building. Findings include: On 12/9/22 at 9:00 a.m., during a random tour of the kitchen, with the Kitchen Manager, he was observed with beard growth, stubble, greater than 1/4 inch. He was not wearing a beard cover. On 12/9/22 at 3:37 p.m., during an interview, the Director of Nursing (DON) indicated she did not think the Dietary Manager had a beard. She would have to check to see what the length was (for stubble), which required a beard cover. On 12/9/22 at 3:04 p.m., thee DON provided a current policy, dated 5/2018, titled, "Hair Restraints." This policy indicated "The facility shall adhere to 410 IAC 7-24-138 which states (b). food employees shall wear hair restraints, such as hats, hair coverings nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single use articles...."		regarding the requirement that food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designated and worn to effectively keep their hair from contacting: exposed food, clean equipment, utensils, and linens; and unwrapped single service and single use articles (as per 410 IAC 7-24-138). II. In an effort to identify any other concerns, all food employees shall be re-educated regarding wearing appropriate coverings to prevent potential contamination of food when preparing and serving resident meals. III. Measures to ensure the deficient practice does not recur include monitoring conducted by the Administrator/designee randomly at least three times weekly following aforementioned education. Should non-compliance be observed, the employee shall be immediately corrected and re-educated. IV. The corrective action will be monitored through random observations by the Administrator/designee at least three times weekly for one month, and weekly thereafter for a minimum of six months to confirm continued compliance.	

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R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to follow Centers for Disease Control and Prevention (CDC) guidance during a pandemic to ensure infection control practices for COVID-19 were followed by staff for personal protective equipment (PPE) use for 1 of 3 residents reviewed for infection control (Resident 8). This deficient practice had the potential to effect 34 of 34 residents who resided in the building. Finding include: On 12/9/22 at 12:10 p.m., during a random observation, Resident 8 was observed as he propelled his wheelchair from a vacant apartment to his own apartment. He was dressed in street clothes and wore a cloth mask. A Home Health Aid followed Resident 8 down the hall to his apartment. She was dressed in a cover gown, gloves, face shield, and N-95 mask. The vacant apartment, number 110, had a Green sign on the door, which signified it was not a COVID-19 contaminated room. There was no	R 0407	**R 407** I. The shower of Resident #8 will be repaired. The involved staff member was -re-educated as to the need to encourage a resident who is COVID positive to wear an N95 mask should the resident have need to exit his/her apartment while still requiring transmission-based precautions. II. No other residents were affected. III. Measures to ensure the deficient practice does not recur include staff education as to the wearing of appropriate PPE should a resident be COVID positive, hanging of appropriate cautionary signs for any error being occupied by a resident who is COVID positive, and necessary actions/cleaning following the occupying of an area by a resident	01/19/2023

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	Personal Protective Equipment (PPE) cart outside the room or trash can to dispose of PPE. The door to the apartment stood open and accessible. On 12/9/22 at 12:20 p.m., during an interview, the Home Health Aid indicated she had to take Resident 8 across the hall to the other apartment to get a shower. His shower (in his apartment) did not work. On 12/9/22 at 3:37 p.m., during an interview, the Director of Nursing (DON) indicated Resident 8's shower was broken. It had been broken for 2 to 3 weeks. They had the parts to fix it but had to have someone come out. It was more than their maintenance person could do. Resident 8 should not have been in the hall without an N-95 mask on. He should not have been wearing a cloth mask in the hall. The Home Health Aid should have removed PPE in the apartment, to walk through the hall, then put on new PPE to enter the second apartment. Apartment 110 should have been identified with a "Red Stop" sign to identify it as a contaminated room, since he was COVID-19 positive and using that apartment (to shower). On 12/9/22 at the entrance conference, the Administrator provided a current policy, dated 10/15, titled, "Isolation (Transmission-Based Precautions) Guidelines." This policy indicated, "When a resident is to be transported, cover the conveyance with a clean sheet. Place the on resident on the conveyance and cover him/her with another clean sheet. Those on airborne or droplet precautions must wear a mask."		who is COVID positive. IV. The corrective action will be monitored by the Administrator/designee, ensuring that should a resident be reported as COVID positive, a visual inspection to confirm areas occupied by that resident are clearly labeled with necessary precautions, and PPE is readily available and being used by applicable staff. Monitoring for correct use will be conducted randomly on at least a daily basis throughout the duration of precautions in place for any resident of the facility. This shall be the practice ongoing. Should non-compliance be observed, immediate corrective action and re-education shall be conducted.	