STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155839	A. BUILDING -- B. WING	09/25/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/25/24 Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730 At this Emergency Preparedness survey, Summit Health and Living was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 34 certified beds. At the time of the survey, the census was 29. Quality Review completed on 09/26/24	E 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Health & Living that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Health & Living. The facility requests the following plan of correction be considered its allegation of compliance. The facility also respectfully requests paper compliance due to the low scope of the tags cited.	
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: 09/25/24 Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730 At this Life Safety Code survey, Summit Health and Living was found not in compliance with	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Health & Living that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Health & Living. The facility requests the following plan of correction be considered its allegation of compliance. The facility also respectfully requests	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anastasia Key	HFA	10/22/2024

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	Requirements for Participation in Medicare, 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 one-story facility was determined to be of Type II (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 34 and had a census of 29 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one barn used for storage which was not sprinklered. Quality Review completed on 09/26/24		paper compliance due to the low scope of the tags cited.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy kitchen. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5.	K 0324	Therapy kitchen range did not have a shutoff switch or a breaker in the electrical box which would interrupt power to the appliance. J. Barr Electric installed a new 60 amp disconnect by the therapy kitchen range on September 27, 2024. Invoice attached. Staff was educated regarding use of the disconnect switch. Education attached. 10/22/24 The Maintenance Director spoke	11/15/2024

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	(3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect 3 residents in the therapy kitchen. Findings include: Based on observations and interview on 09/25/24 between 10:40 a.m. and 12:30 p.m. during a tour of the facility with the Maintenance Director (MD), there was an electric 4 burner range in the therapy kitchen that had power to it and was not in use. The MD searched but could not locate a shutoff switch or the breaker in the electrical box which would interrupt power to the appliance. The MD stated that a shut off switch would need to be installed near the appliance. This finding was reviewed with the MD at the time of discovery and again at the exit conference with the MD and Administrator present. 3.1-19(b)		with our electrical contractor on October 21, 2024. The contractor stated that he would need time to gather materials for installation of the timer. He stated that this could take a few weeks. He was in agreeance that he could complete installation by November 15, 2024 so that will be our new date of compliance. Will attach pictures when installation is complete. ="" p=""> ="" p="">	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line	K 0353	The internal inspection of piping documentation from the facility contractor was out of date. Elwood Fire completed our five year internal pipe inspection September	09/26/2024

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	conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on records review on 09/25/24 from 8:50 a.m. to 10:30 a.m. with the Maintenance Director and Administrator, the internal inspection of piping documentation from the facility contractor was dated 05/09/19 and was more than 5 years old. The MD stated that he was in communication with the contractor who was coming as early as the next day to preform the internal pipe inspection. The contractor did notify the MD during the survey that they were intending to come the next day. This finding was reviewed with the MD at the time of discovery and again at the exit conference with the MD and Administrator present. 3.1-19(b)		26, 2024. Report states, "No blockages and little to no debris were found in the Wet Sprinkler System. System overall found to be in good condition at the locations of inspection. No further action needs to be taken at this time." Copy of report attached. This was added to TELS and will recur every 60 months, next scheduled date is September 2029.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations and interview on 09/25/24 between 10:40 a.m. and 12:30 p.m. during a tour of	K 0363	Resident room 136P door did not latch. It was repaired on September 30, 2024. The wooden door was sanded down at the bottom to allow it to latch. New Resident Room Door audit form was created. Audit form and pictures attached. This was added to TELS and will recur monthly.	09/30/2024

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	the facility with the Maintenance Director (MD), the corridor door to Resident Room 136 failed to close and latch positively into the door frame. Based on interview at the time of the observations, the MD agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. The MD stated that some plastic trim would need to be trimmed to allow the door to close and latch. This finding was reviewed with the MD at the time of discovery and again at the exit conference with the MD and Administrator present. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of pipe through 1 of 1 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of	K 0372	Ceiling hole in utility room was repaired on September 30, 2024 with drywall and mud. After Construction audit form was created and will be completed after any construction is done by an outside contractor on or above the ceiling. Audit form and pictures attached.	09/30/2024

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	restricting the movement of smoke. This deficient practice could affect 3 staff. Findings include: Based on observations and interview on 09/25/24 between 10:40 a.m. and 12:30 p.m. during a tour of the facility with the Maintenance Director (MD), the room marked as "Utility #4" had an approximate 12 inch by 15 inch hole in the ceiling near where some new pipes had been installed in the ceiling some barrier. The MD stated that recently some old Asbestos material had been removed and the new copper pipes had been installed however the ceiling had not been completely repaired. This finding was reviewed with the MD at the time of discovery and again at the exit conference with the MD and Administrator present. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation, and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or	K 0914	The most recent itemized listing of inspection and testing of electrical outlet receptacles showed the annual test last completed was out of date. Annual receptacle testing was completed September 27, 2024. TELS Receptacle Testing form was used. Completed form attached. This was added to TELS and will recur yearly, next scheduled date is February 2025.	09/27/2024

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	servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all staff and residents. Findings include: Based on records review on 09/25/24 from 8:50 a.m. to 10:30 a.m. with the Maintenance Director and Administrator, an itemized listing of inspection and testing electrical outlet receptacles for the most recent twelve-month period was not available for review. The most recent documentation showed the annual test last completed on 02/13/23. Based on interview at the time of record review, the Maintenance Director stated that he is only part time at this facility and he was aware of the testing being expired but had not gotten it completed for this facility. This finding was reviewed with the MD at the time of discovery and again at the exit conference with the MD and Administrator present. 3.1-19(b)			