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	09/06/2024

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00442289, IN00441075, IN00441073 & IN00441071 Complaint IN00442289 - No deficiencies realted to the allegations are cited. Complaint IN00441075 - State deficiencies related to the allegations are cited at R0383. Complaint IN00441073 - No deficiencies realted to the allegations are cited. Complaint IN00441071 - No deficiencies realted to the allegations are cited. Survey date: Septemeber 5 and 6, 2024. Facility number: 011840 Residential Census: 40 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on September 12, 2024.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of State Law. The Plan of Correction is submitted in order to respond to the allegation of deficiency cited during complaint survey event ID: VBWN11. Please accept this plan of correction as the provider's credible allegation of compliance as of September 19, 2024. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency Based on interview and record review, the facility failed to ensure residents with diagnoses of major mental illness had person-centered comprehensive care plans initiated and implemented in corroboration with their mental health provider for 3 of 3 residents reviewed for major mental illness (Residents J, M, and N).	R 0383	A comprehensive care plan was developed for those Residents identified at the time of survey as lacking a said plan to address major mental illness (MMI). As other residents could be affected, an audit of all residents	09/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
brittany	mckinney	09/19/2024

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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	Findings include: 1. On 9/5/24 at 11:00 a.m., Resident J's medical record was reviewed. He had diagnoses which included, but were not limited to, major depressive disorder, delusional disorder, and intellectual disabilities. He had current physician's orders, on the September 2024 orders, for Fluoxetine (an antidepressant medication) and Clonazepam (an anti-anxiety medication). A nursing progress note, dated 4/30/24 with no time, indicated "... [Resident J] continues to be inappropriate with staff. [Resident J] states things like, 'oh my girl' 'come sit on my lap'...." A nursing progress note, dated 8/8/24 at 8:45 a.m., indicated, "...writer had a conversation with resident about personal space. Resident continues to give staff and residents unwelcoming hugs and getting too close in personal space. Resident was redirected and agrees to keep his hands to himself..." A neurobehavioral progress note, dated 6/13/24, indicated, "... [Resident J] reported feeling better and stated, "I'm doing better" particularly in connections with a recent altercation with a peer, which he reported had been resolved amicably...." Resident J had a service plan, dated 5/22/24, which indicated, " ...Behavior: ... has inappropriate outbursts towards staff and other residents ... is easily redirected ... will continue through next review ..." The service plan lacked person-centered goals and/or approaches to		was conducted to identify any other residents of the facility with a current diagnosis meeting the definition of major mental illness. A comprehensive careplan was then developed to address said major mental illness. In an effort to ensure compliance with the development of a comprehensive care plan for applicable residents within thirty (30) days of admission to residential care, the Administrator shall be responsible to ensure the prospective resident is first screened for major mental illness. If MMI is identified, a comprehensive careplan shall be developed, in an effort to ensure appropriate goals and interventions are developed for the individual resident. The careplan shall then be reviewed on a quarterly basis, at the time of Service Plan review. As a means to ensure ongoing compliance, the Regional Director shall review all newly admitted residents on a monthly basis for a minimum of six months and shall confirm the development of the comprehensive care plan addressing MMI within thirty (30) days for applicable residents. Should non-compliance be observed, corrective action shall be taken.	

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	address his behaviors in collaboration with his mental health provider. Resident J's record lacked documentation of a person-centered care plan to address his mental illness, behaviors and/or provide specific goal and interventions to address his needs. 2. On 9/5/24 at 11:30 a.m., Resident M's medical record was reviewed. He had diagnoses which included, but were not limited to, major depressive disorder, recurrent and moderate. He had current physician's order, on September 2024 orders, for Quetiapine (an antipsychotic medication) and Fluoxetine. A neurobehavioral progress note, dated 6/30/24, indicated, " ...[Resident M] was seen for depression. He endorsed some aspects of apathy and avolition, appearing disinterested in engaging in activities on this particular day ... he mentioned that his relationship with his sister was currently on a 'down cycle' with her expressing frustration towards him, which he feels is displaced frustration ...." Resident M had a service plan, dated 6/13/24, which indicated, he did have " ...attitudes, disturbances and emotional states create daily difficulties, which are extremely difficult to modify to tolerable levels and can only be modified in a special setting and/or with a special plan ...." The service plan lacked specifications of a special plan or special setting. Resident M's record lacked documentation of a person-centered care plan to address his mental			

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	illness, behaviors, and/or provide specific goal and interventions to address his needs. 3. On 9/5/24 at 12:00 p.m., Resident N's medical record was reviewed. He had diagnoses which included, but were not limited to, bipolar disorder and manic depressive disorder. He had current physician's order, on the September 2024 orders, for Mirtazapine (an antidepressant medication). A neurobehavioral progress note, dated 6/30/24, indicated, " ...[Resident N] was being seen in follow up for bipolar disorder ... the patient's presentation is consistent with bipolar disorder, which is characterized by mood fluctuations between depressive and manic episodes ...." Resident N had a service plan, dated 6/13/24, which indicated, he did not have behavioral/emotions limitations. Resident N's record lacked documentation of a person-centered care plan to address his mental illness, behaviors, and/or provide specific goal and interventions to address his needs. During an interview on 9/6/24 at 10:35 a.m., the Regulatory Consultant (RC) indicated it appeared that there had not been a process in place to identify, assess and implement comprehensive care plan for residents with major mental illness. On 9/6/24 at 12:30 p.m., the RC indicated there was no specific policy which addressed the implementation of comprehensive care plans for individuals with major mental illness, but the			

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	facility should follow the Residential Rules. This citation relates to Complaint IN00441075.			