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	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit City Nursing and Rehabilitation	2940 N Clinton St Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident was informed of and able to participate in treatment decisions for 1 of 3 residents reviewed (Resident C).Findings include:A report, dated 11/6/25, alleged Resident C's medications were not being given as prescribed and the resident not informed of reason for changes in his treatment.On 12/3/25 at 2:23 P.M., Resident C's record was reviewed. Diagnoses included chronic pain syndrome and polysubstance abuse.A hospital progress note, dated 9/3/25, indicated Resident C had been hospitalized for acute/chronic respiratory failure. The note indicated the resident had chronic pain syndrome with a history of polysubstance abuse. He was prescribed Methadone and was followed by the methadone clinic near his hometown. The resident was discharged to the nursing facility with orders for Methadone 10 milligrams (mg) per 1 milliliter (ml): give 12.5 ml by mouth every day. His next dose was due on 9/5/25 at 9:00 a.m.A social services admission Minimum Data Set (MDS) documentation note, dated 9/5/25, indicated Resident C had no cognitive impairment and was able to make decisions for himself.An initial care conference form, dated 9/5/25 at 3:09 p.m., indicated staff met to discuss Resident C's Road to Recovery. The form listed attendees at the meeting, but did not include the resident. The form indicated Resident C's goal of care was to get his tracheostomy out and work through therapy. His medications were reviewed and reconciled.Care plans, dated 9/8/25, indicated the resident had a history of substance use disorder and was at risk for drug seeking behaviors, relapse and/or drug use. He had a diagnosis of chronic pain with the risk of having pain. The care plan didn't indicate Resident C's chronic pain and substance use disorder was managed with use of methadone through the methadone clinic. Methadone was retrieved from Drugs.com on 12/4/25. The article indicated methadone was a long acting opioid medication used to reduce withdrawal symptoms in people addicted to narcotics and was used for chronic pain management. When used to reduce withdrawal symptoms, methadone was only available through approved opioid treatment programs that provided regular monitoring, counseling, and routine drug testing. Withdrawal from methadone varied from person to person and could last from 2-3 weeks up to 6 months. Withdrawal symptoms included anxiety, restlessness, drug cravings, tiredness, muscle cramps, nausea, vomiting, diarrhea and depression.A physician order, dated 9/4/25, indicated to give Methadone concentrate 10mg/ml; give 12.5 ml (total dosage-125 milligrams) by mouth for chronic pain syndrome every day.A Nurse Practitioner (NP) note, dated 9/5/25 at 6:50 p.m., indicated Resident C had been hospitalized for acute/ chronic respiratory failure, was placed on a ventilator and required a tracheostomy. The note indicated the NP was asked to transition Resident C to Suboxone (used for opiate addiction but not used for pain) in place of Methadone. There was little information provided by the hospital and the NP was going to request a discharge summary.The NP note did not indicated the transition from Methadone to Suboxone had been discussed with Resident C including risks, withdrawal symptoms, benefits, and alternative treatments.An NP note, dated 9/8/25, indicated Resident C was seen for management of opioid dependency. The resident had been on methadone to wean off of opioids and had his dose decreased when admitted to the facility. His methadone would be decreased to 10 mg per day, and staff would continue to monitor for withdrawal. When he tolerated the current dose for 72 hours, the dose would continue to be decreased. When the resident was unable to tolerate the decrease, he would consider changing to Suboxone.The NP note did not indicated the transition from Methadone to Suboxone had been discussed with Resident C including risks, withdrawal symptoms, benefits, and alternative treatments.A physician order, dated 9/8/25, indicated to give methadone 10 mg/5 ml; give 5 ml one time per day.A nurse progress note, dated 9/8/25 at 1:51 p.m., indicated Resident C's methadone dose was decreased to 5 ml daily and the resident was aware.An NP note and nurse progress notes, dated 9/8/25, didn't indicate the resident understood the significant change in his methadone dosage and was agreeable to the change, nor were the risks, benefits, and alternatives to decreasing the methadone dose discussed with the resident.An NP note, dated 9/19/25, indicated Resident C was seen for management of methadone. The resident had tolerated reducing the methadone dose for at least 7 days. The methadone dose would be decreased to 2 ml per day, and staff would monitor for signs of withdrawal. The NP note did not indicate the resident was notified and understood the decrease in his methadone dose. The note didn't indicate the resident was agreeable to the change nor were the risks, benefits and alternatives discussed with Resident C.A nurse progress note, dated 9/20/25, indicated Resident C had been upset that morning because his methadone dose had been reduced. He indicated he didn't understand why there were changes due to his long-term use status and being a patient of a methadone clinic. The NP was