

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155839	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  Summit Health and Living		STREET ADDRESS, CITY, STATE, ZIP CODE  701 S Main St Summitville, IN 46070	

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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to prevent the neglect of a dependent resident when CNA 1 did not implement the resident's care plan interventions nor follow manufacture's guidelines for the operation of a mechanical lift, resulting in a resident fall when the mechanical lift tipped over during a transfer for 1 of 3 residents reviewed for mobility transfers utilizing a mechanical lift. (Resident B) Findings include: Resident B's clinical record was reviewed on 8/20/25 at 10:10 a.m. Diagnoses included cerebral infarction, vascular dementia, hemiplegia and hemiparesis affecting left non-dominant side, type 2 diabetes, chronic kidney disease, hypertension, anticoagulant use, depressive disorder, and chronic pain syndrome. A current care plan, dated 1/18/21, indicated the resident had an activity of daily living deficit. Interventions included two staff member participation for mobility transfers. The most current quarterly MDS (Minimum Data Set) Assessment, dated 7/10/25, indicated the resident was dependent for transfers to and from a bed to a chair or wheelchair. An undated facility CNA Assignment Sheet indicated Resident B required two-person assist for transfers. A facility self-reportable, dated 7/26/25, indicated, at approximately 4:05 p.m. on 7/26/25, CNA 2 entered Resident B's room. Resident B was in the mechanical lift and lifted high in the air. The only other person in the room was CNA 1. CNA 2 indicated CNA 1 had been transferring the resident from the bed to a high-backed, reclining wheelchair chair alone. CNA 2 called for assistance from the nurses. When LPN 3 entered the room, they observed Resident B on the floor, the mechanical lift tipped over on its side, and CNA 1 and CNA 2 standing nearby. The resident was assessed and sent to the hospital for evaluation and treatment. A written interview between the DON and CNA 1, dated 7/26/25, indicated CNA 1 started the mechanical lifting process without assistance from another staff member. In a written statement, dated 7/26/25, CNA 2 indicated she was searching for the mechanical lift. She entered Resident B's room and saw the resident lifted into the air via the mechanical lift with only one operator present. CNA 1 pushed the machine forward, and the resident fell to the floor. CNA 2 indicated CNA 1 never asked for assistance with the transfer. In a written statement, dated 7/26/25, LPN 3 indicated she heard staff yelling for RN 4. She went to the room and found Resident B on the floor with CNA 1 and CNA 2 standing nearby. The resident was assessed and returned to bed. LPN 3 indicated she had never seen CNA 1 attempt to use the mechanical lift without assistance. However, after the incident, she became aware CNA 1 had attempted the transfer without assistance. In a written statement, dated 7/26/25, RN 4 indicated she heard staff calling her name. When she arrived at Resident B's room, she observed the resident on the floor and was told he fell from the mechanical lift. CNA 2 told her when she entered the room, the resident was already in the mechanical lift sling, and it was elevated to the highest position. The machine tipped over, causing the resident to fall to the floor. During an interview on 8/20/25 at 10:54 a.m., the DON indicated CNA 1 was no longer an employee of the facility. CNA 1 was not available for interview during this survey. During an interview on 8/20/25 at 11:02 a.m., Resident B indicated he was dropped from the mechanical lift. The resident was unable to remember who was involved or specifics about the incident. The resident indicated he had a bad headache and was sent to the hospital. During an interview on 8/20/25 at 11:14 a.m., CNA 5 indicated staff have always been required to use two people to operate mechanical lifts. During an interview on 8/20/25 at 11:23 a.m., the Maintenance Supervisor indicated the mechanical lift was checked after the incident and they were unable to find anything wrong with the function of the lift. During an interview on 8/20/25 at 11:25 a.m., CNA 6 indicated staff always used two staff members to operate a mechanical lift. She denied any problems finding someone to help. Staff used CNA assignment sheets to see what type of care the residents needed. During an interview on 8/20/25 at 11:40 a.m., RN 4 indicated she heard staff yelling for her. When she arrived at the resident's room, she observed the resident on the floor with the lift pad under him. Staff used the lift pad to move the resident closer to the bed and lift him back onto the bed. The resident was assessed for injuries and sent to the hospital. After the incident, RN 4 was informed that the resident was already in the mechanical lift and elevated when the CNA 2 arrived at the room. To operate a mechanical lift in this facility, there must be two people present. During an interview on 8/20/25 at 12:03 p.m., CNA 2 indicated she entered the resident's room and observed Resident B up in the air. The resident was positioned over a high-backed, reclining wheelchair. The chair was not positioned in a laid-back position appropriate for transfers. The resident started to fall, and the machine tipped over. CNA 2 indicated she tried to reach the resident but was unsuccessful. The resident complained of a headache. He was sent to the hospital. There should always be two people present to operate the mechanical lift. During an interview on</p>		