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	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health and Living	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident's right to make choices and to promote independent activities of daily living. (Resident B and CNA 1)Findings include:During an interview on 1/14/26 at 10:50 a.m., QMA 2 indicated on 12/29/25, CNA 1 asked the QMA for assistance showering Resident B. During the shower, CNA 1 was rude and demanding with the resident. CNA 1 moved the resident to the corner, away from the showerhead. During the shower, the resident reached for the showerhead. CNA 1 indicated to the resident that he (Resident B) was not allowed to have the showerhead, and staff were told he wasn't to have it. QMA 2 indicated she had never been told the resident could not have the showerhead, nor was it in his plan of care. The resident reached for the showerhead again. CNA 1 told the resident he was not allowed to have the showerhead, and they began a tug-of-war for the showerhead.During an interview on 1/14/26 at 12:44 p.m., Resident B indicated he was satisfied with his care at the facility. There was one staff person who was not nice and would not give him the showerhead during his shower. The staff member was CNA 1. The resident indicated the incident had upset him, but he was not harmed physically. The resident indicated he likes to do whatever he could for himself and staff were good about helping him.During an interview on 1/14/26 at 12:54 p.m., CNA 3 indicated she was unaware of anyone being told Resident B was not allowed to have the showerhead. The resident had been known to spray staff while in the shower, but not consistently. The resident should be able to have the showerhead if he asked for it.During an interview on 1/14/26 at 2:20 p.m., the MDS Coordinator indicated Resident B should have been allowed to have the showerhead. During an interview on 1/14/26 at 3:08 p.m., the DON indicated Resident B was allowed to have the showerhead. The resident had never been restricted from having the showerhead. The facility saw this as a resident right violation. It came up in the investigation that some of the aides had not allowed Resident B to have the showerhead because he sprayed them. CNA 1 was not available for interview during the survey.Resident B's clinical record was reviewed on 1/14/26 at 11:31 a.m. Diagnoses included vascular dementia without behavioral disturbance, anxiety, and cerebral infarction due to thrombosis of right posterior cerebral artery.The most current quarterly Minimal Data Set assessment (MDS), dated [DATE], indicated Resident B was moderately cognitively impaired. The resident had impaired function to the left side upper and lower extremities and was dependent for toilet hygiene, shower/bathe, dressing of the lower body, footwear, personal hygiene, and all transfers.A current care plan for ADLs (Activities of Daily Living) was dated 11/12/25. Interventions included staff to encourage the resident to participate to the fullest extent possible with each interaction. The care plan lacked an intervention to restrict the resident from using the showerhead.A CNA assignment sheet, dated 12/29/25, lacked indication the resident should not be allowed to hold the showerhead during bathing. Behavior progress notes, dated October 2025 through 1/14/26 indicated four times that the resident was not allowed to have the showerhead after asking for it: 10/30/25 at 3:55 p.m., (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/14/25 at 4:58 p.m., 11/24/25 at 8:12 p.m., and 12/8/25 at 7:53 p.m.An undated staff education form, titled Know Your Rights under Federal Nursing Home Regulations was provided by the Administrator on 1/14/26 at 3:49 p.m. The form indicated the following: Resident RightsYou have the right do a dignified existence, self-determination, and communication access to persons and services inside and outside the facilityRespect and DignityYou have the right to be free from abuse, neglect, misappropriation of your property, exploitation, corporal punishment or involuntary seclusion.The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences except when to do so would endanger the health or safety of you or other residents.Self-determinationYou have the right to and the facility must promote and facilitate self-determination through support of resident choice, including: .You have the right to make choices about aspects of your life in the facility that are significant to you.This citation relates to Intake 2704766.3.1-3 (a) (1)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident's right to be free from verbal abuse by a staff member (Resident B and CNA 1).Findings include:During an interview on 1/14/26 at 10:50 a.m., QMA 2 indicated, on 12/29/25, CNA 1 asked for assistance showering Resident B. During the shower, CNA 1 was rude and demanding with the resident. CNA 1 moved the resident to the corner of the shower, away from the showerhead. During the shower, the resident reached for the showerhead. CNA 1 told the resident he (Resident B) was not allowed to have the showerhead and staff had been told so. QMA 2 indicated she had never been told the resident could not have the showerhead. During the shower, the resident indicated they needed to urinate. When the resident was finished, they continued with the shower. CNA 1 threw a washcloth at the resident and told him to wash his junk. QMA 2 assisted the resident in cleaning his private area. The resident reached for the showerhead again. CNA 1 told the resident he was not allowed to have the showerhead, and they began a tug-of-war for the showerhead and CNA 1 jerked it away from the resident. QMA 2 attempted to keep the resident from becoming more upset, by continuing care, but did not stop CNA 1 nor ask her to leave the area. CNA 1 and QMA 2 got the resident back to his room and the resident thanked QMA 2. The resident then thanked CNA 1, but she did not respond. The resident had to thank her twice before she responded with a sarcastic you're welcome. QMA 2 did not know if CNA 1 and Resident B had any other interactions for the rest of the shift (2:00 p.m. - 10:00 p.m.). QMA 2 indicated the shower encounter started between 3:00 p.m. and 3:30 p.m. QMA 2 indicated she considered the encounter abusive. QMA 2 indicated the resident was upset and didn't think he had done anything wrong. He had never been told he was not allowed to have the showerhead. At one point the resident told QMA 2 this was bull shit. During an interview on 1/14/26 at 12:44 p.m., Resident B indicated he was satisfied with his care at the facility. There was one staff person who was not nice and would not give him the showerhead during his showers. He identified that staff member as CNA 1. The resident indicated the incident had upset him but he was not harmed physically. The resident indicated he liked to do whatever he could for himself and staff were good about helping him.Resident B's clinical record was reviewed on 1/14/26 at 11:31 a.m. Diagnoses included vascular dementia without behavioral disturbance, anxiety, and cerebral infarction due to thrombosis of right posterior cerebral artery.The most current quarterly Minimal Data Set assessment (MDS), dated [DATE], indicated Resident B was moderately cognitively impaired. The resident had impaired function to the left side upper and lower extremities and dependent for toilet hygiene, shower/bathe, dressing of the lower body, footwear, personal hygiene, and all transfers.A current care plan, dated 1/18/21, indicated Resident B had impaired cognitive functioning or impaired thought process related to vascular dementia. Interventions included keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion.A facility self-reported incident, dated 12/30/25 at 5:23 p.m., indicated QMA 2 reported on 12/29/25 at 6:01 p.m., an uncomfortable situation occurred between CNA 1 and Resident B. During a shower, CNA 1 pushed the resident into the corner of the shower furthest away from the showerhead. The resident grabbed for the showerhead and started to bathe themselves. CNA 1 took it away and refused to let the resident have it and stated staff were not supposed to let the resident have the showerhead. CNA 1 continued to wash the resident's upper body and QMA 2 washed the resident's legs. CNA 1, then gave the resident a washcloth and told them to wash their junk. QMA 2 assisted the resident in washing the lower body. The resident stated they had to urinate. After they finished, the resident grabbed the showerhead and CNA 1 tried to take it away. They continued a tug-of-war with the (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showerhead. CNA 1 demanded the resident return the showerhead because they were not allowed to have it. The resident became upset and stated other staff members allow him to have the showerhead. CNA 1 resumed the shower. After the shower, the resident thanked both staff members sincerely. CNA 1 used a sarcastic tone while saying You're welcome. The facility asked QMA 2 why the incident was not reported immediately. QMA 2 indicated she did not feel it needed to be reported because the resident as not harmed, in distress and QMA 2's focus was to avoid further conflict by continuing to assist with resident care. QMA 2 reported that CNA 1's was pleasant and cooperative prior to and after the encounter. However, during the encounter CNA 1's attitude changed as evidenced by a change in the tone change when care was being provided to Resident B. The Resident was interviewed and their story corroborated with QMA 2's. The resident further alleged that CNA 1 had jerked the showerhead away from him. The resident also stated that CNA 1 dumped shampoo on his head and wouldn't put it in his hand. The resident said other care givers allow him to complete what he can and then provide assistance. The resident stated CNA 1 threw a washcloth at him and told him to wash his junk.CNA 1 was not available for interview during the survey.A current facility policy, dated 10/2017, titled Reporting of Reasonable Suspicion of a Crime, Reporting, Investigate/Prevent/Correct Any Alleged Violations was provided by the Administrator on 1/14/26 at 3:49 p.m. The policy indicated the following: Policy: It is the policy of the Community Long Term Care that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, exploitation, and involuntary seclusion. The resident has the right to be free from mistreatment, neglect, and misappropriation of property. Resident must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants or volunteers, staff of other agencies service the resident, family members, legal guardians, friends, or other individuals.This citation relates to Intake 2704766.3.1-27(b)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff (QMA 2) intervened to protect a resident (Resident B), who was verbally abused by another staff member (CNA 1). The facility also failed to ensure staff reported the allegation of verbal abuse of a resident (Resident B) by another staff member (CNA 1) in a timely manner to the Administrator, resulting in the facility failing to report the suspicion/actual verbal abuse to the appropriate regulation agencies in a timely manner. Findings include:Resident B's clinical record was reviewed on 1/14/26 at 11:31 a.m. Diagnoses included vascular dementia without behavioral disturbance, anxiety, and cerebral infarction due to thrombosis of right posterior cerebral artery.The most current quarterly Minimal Data Set assessment (MDS), dated [DATE], indicated Resident B was moderately cognitively impaired. The resident had impaired function to the left side upper and lower extremities and dependent for toilet hygiene, shower/bathe, dressing of the lower body, footwear, personal hygiene, and all transfers.A current care plan, dated 1/18/21, indicated Resident B had impaired cognitive functioning or impaired thought process related to vascular dementia. Interventions included keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion.A current care plan, dated 8/3/22, indicated Resident B could be verbally abusive with staff. Interventions included caregivers were to provide opportunities for positive interactions. A current care plan, dated 1/18/21, indicated Resident B had impaired cognitive functioning or impaired thought process related to vascular dementia. Interventions included keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion.A current care plan for ADLs (Activities of Daily Living), dated 11/12/25, indicated interventions included staff to encourage the resident to participate to the fullest extent possible with each interaction.A facility self-reported incident, dated 12/30/25 at 5:23 p.m., indicated QMA 2 reported on 12/29/25 at 6:01 p.m., an uncomfortable situation occurred between CNA 1 and Resident B. During a shower, CNA 1 pushed the resident into the corner of the shower furthest away from the showerhead. The resident grabbed for the showerhead and started to bathe themselves. CNA 1 took it away and refused to let the resident have it and stated staff were not supposed to let the resident have the showerhead. CNA 1 continued to wash the resident's upper body and QMA 2 washed the resident's legs. CNA 1, then gave the resident a washcloth and told them to wash their junk. QMA 2 assisted the resident in washing the lower body. The resident stated they had to urinate. After they finished, the resident grabbed the showerhead and CNA 1 tried to take it away. They continued a tug-of-war with the showerhead. CNA 1 demanded the resident return the showerhead because they were not allowed to have it. The resident became upset and stated other staff members allow him to have the showerhead. CNA 1 resumed the shower. After the shower, the resident thanked both staff members sincerely. CNA 1 used a sarcastic tone while saying You're welcome. The facility asked QMA 2 why the incident was not reported immediately. QMA 2 indicated she did not feel it needed to be reported because the resident as not harmed, in distress and QMA 2's focus was to avoid further conflict by continuing to assist with resident care. QMA 2 reported that CNA 1's was pleasant and cooperative prior to and after the encounter. However, during the encounter CNA 1's attitude changed as evidenced by a change in the tone change when care was being provided to Resident B. The Resident was interviewed and their story corroborated with QMA 2's. The resident further alleged that CNA 1 had jerked the showerhead away from him. The resident also stated that CNA 1 dumped shampoo on his head and wouldn't put it in his hand. The resident said other care givers allow him to complete what he can and then provide assistance. The resident stated CNA 1 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	threw a washcloth at him and told him to wash his junk.During an interview on 1/14/26 at 10:50 a.m., QMA 2 indicated, on 12/29/25, CNA 1 asked for assistance showering Resident B. During the shower, CNA 1 was rude and demanding with the resident. CNA 1 moved the resident to the corner of the shower, away from the showerhead. During the shower, the resident reached for the showerhead. CNA 1 told the resident he (Resident B) was not allowed to have the showerhead and staff had been told so. QMA 2 indicated she had never been told the resident could not have the showerhead. During the shower, the resident indicated they needed to urinate. When the resident was finished, they continued with the shower. CNA 1 threw a washcloth at the resident and told him to wash his junk. QMA 2 assisted the resident in cleaning his private area. The resident reached for the showerhead again. CNA 1 told the resident he was not allowed to have the showerhead, and they began a tug-of-war for the showerhead and CNA 1 jerked it away from the resident. QMA 2 attempted to keep the resident from becoming more upset, by continuing care, but did not stop CNA 1 nor ask her to leave the area. CNA 1 and QMA 2 got the resident back to his room and the resident thanked QMA 2. The resident then thanked CNA 1, but she did not respond. The resident had to thank her twice before she responded with a sarcastic you're welcome. QMA 2 did not know if CNA 1 and Resident B had any other interactions for the rest of the shift (2:00 p.m. - 10:00 p.m.). QMA 2 indicated the shower encounter started between 3:00 p.m. and 3:30 p.m. QMA 2 indicated she considered the encounter abusive. QMA 2 indicated the resident was upset and didn't think he had done anything wrong. He had never been told he was not allowed to have the showerhead. At one point the resident told QMA 2 this was bull shit. During an interview on 1/14/26 at 12:00 p.m., the Administrator indicated the CNA's used assignment sheet for resident care information. Review of the facility's CNA assignment sheets lacked indication that Resident B was not able to use the showerhead himself. During an interview on 1/14/26 at 12:44 p.m., Resident B indicated he was satisfied with his care at the facility. There was one staff person who was not nice and would not give him the showerhead during his showers. He identified that staff member as CNA 1. The resident indicated the incident had upset him but he was not harmed physically. The resident indicated he liked to do whatever he could for himself and staff were good about helping him.During an interview on 1/14/26 at 12:54 p.m., CNA 3 indicated she was unaware of anyone being told Resident B was not allowed to have the showerhead. The resident had been known to spray staff while in the shower, but this did not happen consistently. The resident should be able to have the showerhead if he asked for it. CNA 3 indicated that the resident usually asked her to put shampoo in his hand and he washed his hair himself.During an interview on 1/14/26 at 1:09 p.m., CNA 4 indicated he worked with CNA 1 in the past while she provided care for Resident B. During that time CNA 1 was not nice to the resident. CNA 4 never reported the concerns.During an interview on 1/14/26 at 3:08 p.m., the DON indicated it was the expectation of the facility that staff protect the resident first then immediately report suspected or actual abuse to the Administrator. If the Administrator was not available, staff would report to the DON. QMA 2 should have reported the concern immediately. CNA 1 should not have remained in the facility. If the incident had been handled appropriately, CNA 1 and the resident would have been separated and CNA 1would have been sent home pending investigation. The DON indicated Resident B was allowed to have the showerhead. The facility saw this as a resident's rights violation. It came up in the investigation that some of the aides had not allowed Resident B to have the showerhead because he sprayed them. CNA 1 was not professional when she told the resident he could not have the showerhead and to wash his junk. The DON also indicated all staff should report any concerns of abuse, mistreatment, or neglect immediately.CNA 1 was not available for interview during the survey.CNA 1's timecard was reviewed on 1/14/26 at 3:00 p.m. CNA 1 worked from 1:57 p.m. to 10:10 p.m. on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/29/25.A current policy, dated 10/2017, titled Reporting of Reasonable Suspicion of a Crime, Reporting, Investigate/Prevent/Correct Any Alleged Violations was provided by the Administrator on 1/14/26 at 3:49 p.m. The policy indicated the following: . VII Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should:Respond to the needs of the resident and protect them from further incident (document)Notify the Administrator immediately, Administrator will notify others as applicable.Cross reference F600. This citation relates to Intake 2704766.3.1-28 (c)