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	05/07/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident did not receive an antipsychotic medication without indication when the facility failed to identify targeted behaviors and individualized interventions to support the use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 12)Findings include:During an interview with Resident 12's representative on 4/30/26 at 11:08 a.m., she indicated she felt Resident 12 received quetiapine (an antipsychotic) as a babysitter for the facility. The resident just sat around, and the representative felt like he got tired of doing nothing. During an observation on 4/30/26 at 12:24 p.m., staff assisted Resident 12 with lunch. His eyes were closed much of the time, and he would occasionally open them when staff said his name. During an observation on 5/1/26 at 10:49 a.m., Resident 12 sat near the nurse's station. He held a soft activity book with tactile sensory objects and ran his fingers over the objects. During an observation on 5/1/26 at 2:36 p.m., Resident 12 sat quietly near the nurse's station. Resident 12's clinical record was reviewed on 5/4/26 at 11:22 a.m. Diagnoses included hypersomnia (excessive daytime sleepiness or excessive nighttime sleep), Parkinson's disease, macular degeneration (eye disease affecting vision), generalized anxiety disorder, dementia (unspecified) with other behavioral disturbance, and psychotic disorder with delusions due to known physiological condition. Current physician's orders included quetiapine fumarate 25 mg one half tablet (12.5 mg) by mouth at bedtime (2/19/26) and buspirone (antianxiety) 5 mg one tablet by mouth three times a day (9/16/25). The following quarterly MDS assessments indicated the resident did not exhibit delusions, hallucinations, or behaviors: 5/9/25, 8/5/25, 1/29/26, and 4/28/26. A quarterly MDS assessment, dated 11/4/25, indicated the resident did not exhibit delusions or hallucinations but did exhibit a behavior of swatting or hitting.A current care plan, initiated on 7/24/24, indicated Resident 12 had an alteration in neurological status related to Parkinson's disease progression. Interventions included cueing and reorienting the resident as needed, give medications as ordered, monitor for signs and symptoms of tremors, rigidity, dizziness, changes in level of consciousness, and slurred speech, and reposition/ambulate every two hours as tolerated. A current care plan, initiated 7/24/24, indicated Resident 12 had a communication problem related to a hearing deficit. Interventions included anticipating and meeting the resident's needs, promoting proper communication with others, communicating face to face with television off, observing confounding problems related to a decline in the resident's cognitive status and mood, use communication techniques which enhance interaction, allowing adequate time to respond. Repeat as necessary, do not rush, request feedback from resident for clarification, face the resident when speaking and make eye contact. Turn off television or radio as needed to reduce environmental noise, ask yes/no questions when appropriate, use simple, brief, consistent words and cues, use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures, use effective strategies such as touch, facial expression, eye contact, gestures, tone of voice, non-threatening posture, short direct phrases, speak slowly, speak in a calm, distinct manner, and use a quiet setting for communicating with the resident. A current care plan, initiated on 7/24/24, (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 12 had impaired cognitive functioning/dementia or impaired thought processes related to dementia and Parkinson's disease. Interventions included to use the resident's preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact, reduce any distractions, and use consistent, simple, directive sentences. If the resident would become agitated, stop the interaction and return later. A current care plan, initiated on 7/24/24, indicated Resident 12 was visually impaired related to macular degeneration. He was legally blind in the left eye and the right eye was severely impaired. Interventions included keeping the resident's room and belongings in a specific order to promote independence. A current care plan, initiated on 8/13/24, indicated Resident 12 received psychotropic medications related to behavior management. Interventions included administering medications as ordered, observe and record occurrences of behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others), and document per facility policy, observe/record/report to MD, as needed, side effects and adverse reactions of psychoactive medications such as unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, and behavioral symptoms not usual to the person. A current care plan, initiated on 8/12/24, indicated Resident 12 had a behavior problem related to severely limited vision, decline in cognition, and Parkinson's disease. He might become resistive to care, and yell and swing at staff. Interventions included 1:1 supervision at nurse's station (11/6/24), administer medications as ordered (8/23/24), anticipate and meet resident's needs, provide opportunities for positive interactions, stop and talk to resident when passing him, approach and speak in a calm manner, divert his attention, remove him from the situation and take to an alternate location as needed, attempt to determine underlying cause of behavior(s), considering the location, time of day, persons involved, and the situation, offer snacks and drinks (11/6/24), provide a program of activities that is of interest and accommodates resident's status, and turn on music and give him time to calm down (1/8/26). A current care plan, initiated 8/30/24, indicated Resident 12 received antianxiety medications related to anxiety disorder. Interventions included giving medications as ordered, and monitor for side effects such as drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, mania, hostility, and rage, aggressive or impulsive behaviors, hallucinations, observe for safety related to the use of antianxiety medications which were associated with increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia (falls, broken hips, and broken legs), and observe for target behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.). A current care plan, initiated on 10/29/24 and revised on 11/5/24, indicated Resident 12 had delusions related to acute disease progress with Parkinson's. He saw things that he needed to do and attempted to self-transfer often. He had poor safety awareness and was legally blind, putting him at high risk for falls. Interventions included giving medications as ordered, psychological services as needed, and the use of a pull-tab alarm. A current care plan, initiated 1/13/25, indicated Resident 12 might demonstrate physical behaviors, such as hitting or kicking at staff, related to dementia. Interventions included analyzing key times, places, circumstances, triggers, and what helped de-escalate behaviors, assess for contributing sensory deficits, and assess/anticipate the resident's needs (food, thirst, toileting needs, comfort level, positioning, pain), provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, document observed behavior(s) and attempted interventions in behavior log, consult psychiatric services when needed. When the resident becomes agitated, intervene before agitation escalates, guide the resident away from source of distress, engage him calmly in conversation; if response is aggressive, staff should walk away calmly and approach later. A current care plan, initiated 1/29/25, indicated Resident 12 liked to stand and walk. His memory (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment did not allow him to remember that he was unsafe to stand and walk unassisted. Being able to move about in his environment enriched his senses and helped him maintain his range of motion. It allowed him to feel independent and purposeful. He was unsafe to walk alone but he would still attempt to do so. He was not to be restricted in any way that did not allow him to stand, even when unassisted. Interventions included inviting the resident to activities that promoted exercise (2/26/25), use of a pull-tab alarm (4/29/25), fall assessments with each fall, and staff would follow all safety precautions in place (2/26/25). A current care plan, initiated 4/24/25, indicated Resident 12 took medications that had a blackbox warning (used when clinical data shows the drug can cause severe harm, hospitalization, or death). Interventions included educating the resident and his family about black box warnings, give medications per order, notify the MD of signs and symptoms of black box warning signs observed, and notify the MD about abnormal labs. A current care plan, initiated 5/12/25, indicated Resident 12 took a high-risk antipsychotic medication related to delusions and a mood disorder. Interventions included administering medications as ordered at the lowest dose possible to achieve the desired results, verify medication was swallowed, document AIMS (Abnormal Involuntary Movement Scale) at least quarterly, and observe for potential side effects (pseudoparkinsonism, acute dystonia, akathisia, tardive dyskinesia, anticholinergic effects, hypotension, blood cell disorders, orthostatic hypotension, lethargy, drowsiness, destabilized blood sugar, dizziness), report severe mental status or mood changes, falls, seizures, cardiac arrhythmias, suicidal ideation, new or worsening involuntary movements, implement non-pharmacological interventions per mood/behavior care plan, obtain labs, and report new or worsening symptoms. Resident 12's care plans lacked identification of specific delusions or hallucinations and lacked individualized non-pharmacological interventions to manage or support the resident experiencing delusions or hallucinations.During an observation on 5/4/26 at 10:40 a.m., Resident 12 sat in his wheelchair in the activity area. He was looking in the direction of other residents participating in a group activity. On 5/4/26 at 1:47 p.m., Resident 12 sat outside in his wheelchair with his eyes closed, with a contented look on his face. On 5/4/26 at 3:17 p.m., Resident 12 sat in his wheelchair in his room. His representative talked to him quietly. On 5/6/26 at 9:23 a.m., Resident 12 lay in his bed with eyes closed. On 5/6/26 at 9:58 a.m., Resident 12 sat in his wheelchair near the nurse's station. A staff member asked how he was doing and he responded okay. On 5/6/26 at 10:09 a.m., Resident 12 sat in his wheelchair in the dining room with his eyes closed, while a pastor spoke to the residents. On 5/6/26 at 12:17 p.m., Resident 12 sat in his wheelchair in the dining room. Staff assisted him with eating. On 5/6/26 at 3:21 p.m., Resident 12 sat in his wheelchair, speaking with his representative. On 5/7/26 at 12:11 p.m., Resident 12 sat in his wheelchair in the dining room with his eyes closed. An occurrence note, dated 6/1/2025 at 2:45 p.m., indicated the resident stood, causing his wheelchair to flip, and he landed on his coccyx before staff could reach him. The resident had no safety awareness and tried to stand, unassisted. An IDT note, dated 6/2/2025 at 11:41 a.m., indicated the resident stood from his wheelchair, was observed to fall, landing on his coccyx, and the chair flipped sideways. Two staff members ran towards him, but he fell before they could reach him. The team spoke with hospice regarding frequent falls related to the progression of Resident 12's Parkinson's disease. A behavior note, dated 6/20/2025 at 10:30 p.m., indicated the resident was grabbing at another resident's wheelchair. He attempted to stand several times. Staff intervened with verbal cues, physical assist, toileting, and an activity tool board. An occurrence note, dated 6/30/2025 at 6:00 p.m., indicated the resident was found sitting on the floor with his back to the wall in front of the nurse's station. After a physical assessment, staff put the resident to bed. Confusion was noted to be the root cause of the fall. A progress note, dated 8/2/2025 at 9:57 a.m., indicated the resident did, at times, get anxious and would stand up without assistance or resist care. He was pleasant and cooperative on that shift, with no standing up without assistance. He slept at night and napped during the day. A progress note, dated 8/24/2025 at 10:00 a.m., indicated the resident was found crawling on the floor in his room. A progress note dated 8/25/2025 at 3:48 p.m., indicated the resident continued to attempt to crawl from (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed despite mats, alarms, and low bed position. The Interdisciplinary team (IDT) decided to put Resident 12's bed against the wall to limit possible exit routes from the bed. A psychiatric NP note, dated 10/8/2025 at 10:23 a.m., indicated the resident continued to be extremely restless when awake, constantly moving around in bed to the point of sliding out onto the floor. His mouth moved constantly and he verbalized his racing thoughts, although they made no sense. His anxiety appeared to be stable, and he was due for a review of his antianxiety medication, buspirone. He had been on quetiapine immediate release (IR) 25 mg twice a day at 2:00 p.m., and 9:00 p.m., to target his most struggle-some times of the day. The family preferred he no longer receive the quetiapine in the afternoon, only at bedtime. The family requested psychological services be discontinued. He had been on quetiapine since 2/2025 with fewer falls and fewer behaviors noted. A progress note, dated 10/15/2025 1:22 p.m., indicated the resident was alert and talkative and his appetite was good. He attempted to stand from his wheelchair and was successfully redirected. A progress note, dated 10/29/2025 at 3:06 p.m., indicated the resident displayed increased restlessness since a GDR of his antianxiety medication, buspirone. He attempted to get out of his chair more often, pushed and pulled the dining room table when eating, and was not eating his full meal. He attempted to get up twice that day and the alarm sounded. Staff reported he would ball up his fist but did not swing. Resident 12 displayed impulsivity in the past. Staff provided 1:1 care to settle him down. Staff talked to him, gave him a back rub, and reminded him not to get up. Non-pharmacological interventions were successful. A progress note, dated 12/3/25 at 8:18 a.m., indicated the resident was receiving care from a CNA. He started punching the CNA and said, I'm going to beat the shit out of you. The resident appeared agitated, was offered reassurance, and a new caregiver was provided, resulting in compliance from the resident. A progress note, dated 12/8/2025 7:31 p.m., indicated the resident was resistive during care and kicked a CNA in the chest. He frowned but resistance stopped when care was completed. A progress note, dated 12/9/2025 1:20 p.m., indicated the resident was hitting, agitated and kicking during care, and when assisted getting up or being put to bed. A progress note, dated 1/29/2026 at 1:00 a.m., indicated the resident was calm and cooperative, at times resistive to care. A progress note, dated 2/19/2026 11:00 a.m., indicated the resident was sitting up in bed, confused and slow to engage in conversation. He was calm and when asked a question, he was able to respond after a delay. Resident 12 had a visual deficit that might cause him to react/resist because he was startled, on occasion, with care. He did not know who was there, but when staff explained to him what they were doing, he would comply with care. A progress note, dated 2/25/26 at 6:11 p.m., indicated the resident appeared more awake, was talking out loud, and grabbing on to the handrail while sitting at the nurse's station. A progress note, dated2/28/2026 at 2:33 p.m., indicated staff noticed resident being more playful and attentive since the decrease in quetiapine from 25 mg to 12.5 mg. A progress note, dated 3/4/2026 1:10 a.m., indicated no changes in appetite, behavior, or sleep patterns. A progress note, dated 3/5/2026 at 12:00 p.m., indicated the resident was found on the floor after climbing out of bed. No injuries were noted. A progress note, dated 3/5/26 at 6:06 p.m., indicated the resident was resistive to vital signs assessment. He balled up his fist but did not strike the nurse. His eyes were unreactive to light. A progress note, dated 3/5/26 at 6:41 p.m., indicated the resident attempted to climb out of bed. While in the dining room, waiting for dinner, he picked up the table and staff intervened. When a nurse tried to get vital signs, he balled up his fist but did not strike out. He was more awake and more fidgety. A progress note, dated 3/6/26 at 4:45 p.m., indicated the resident was moving his arms and hands as though he was working.A progress note, dated 3/10/26 at 9:09 p.m., indicated while two CNAs were putting the resident to bed, he punched a male CNA in the arm, lifted his knees and put them into a CNA's rib cage, and tried to kick. One staff held his hands or legs and the other performed peri-care. That behavior was suspected to be triggered by a recent dose reduction in quetiapine. The resident could not be reasoned with, grimaced, and wanted to be left alone. A progress note, dated 3/19/26 at 6:01 p.m., indicated the resident was calm and cooperative at dinner. There were no changes in mood or behavior. A CNA behavior note, dated 3/19/26, indicated (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 12 was pointing at the ceiling. She asked him what he was pointing at and he replied, Those airplanes. The resident was not distressed, and the CNA described his mood as calm.A progress note, dated 4/28/26 at 8:39 a.m., indicated the resident was quiet, without behaviors, slept at night and napped during the day. A progress note, dated 4/27/26 at 5:41 p.m., indicated the resident was calm, pleasant, and exhibited no behavior. A progress note, dated 4/28/26 at 4:11 p.m., indicated Resident 12 verbalized phrases and words with mumbled speech. He was unable to make his wants and needs known. He was quiet and exhibited no behavior. He was resting in bed and usually slept throughout the night except for care times. A progress noted, dated 4/28/26 at 8:39 a.m., indicated Resident 12 was quiet with no behaviors noted. A progress note, dated 4/28/26 at 3:29 p.m., indicated Resident 12 appeared calm and no distress was noted. A CNA behavior note, dated 4/28/26, indicated the resident was observed grabbing something in the air and talking to himself. The CNA did not offer non-pharmacological interventions and the behavior note lacked documentation of the resident's mood at the time. The clinical record lacked documentation of Resident 12 experiencing delusions or hallucinations resulting in stress or discomfort to the resident. A quarterly Minimum Data Set assessment, dated 4/28/26, indicated Resident 12 was severely cognitively impaired, had no indications of psychosis (hallucinations/delusions) and no behaviors. He used a wheelchair for mobility, and was dependent on staff for eating, oral hygiene, toileting, personal hygiene, rolling left to right in bed, sitting to lying, and sitting to standing. He was dependent on staff for all transfers. He received an antipsychotic and antianxiety medication on a routine basis. The last gradual dose reduction (GDR) was attempted on 2/17/26. A bed alarm and a chair alarm were used daily. During an interview with CNA 5 on 5/7/26 at 10:21 a.m., she indicated Resident 12 tried to hit and kick another CNA during peri-care. He did the same type of thing to CNA 5 another time. She was not sure Resident 12 understood what was taking place when care was provided. He would mumble, but was hard to understand. When staff helped him eat, he would sometimes try to say something. Some days, before eating, he would pray. Sometimes, he would reach for things that were not there or while dining, he might pull on the tablecloth. She did not think he was delusional or experiencing hallucinations. Generally, he was just aggressive or combative during care activities. During an interview with Nurse Practitioner (NP) 4 on 5/7/26 at 10:57 a.m., she indicated Resident 12's family no longer wanted her to treat the resident. The family felt like she treated the resident like a [NAME] pig and did not approve of the changes to his medications. Resident 12 was receiving the quetiapine due to delusions related to his Parkinson's disease. Before he was admitted to the facility, he had been very physically active and was an avid kick boxer. Then, he had a fall at home and after his hospitalization, he was never the same again. Upon admission in July of 2024, he was able to ambulate but since that time, his coordination had declined and he could no longer walk. The delusions he had were causing him to get up out of bed frequently, causing multiple falls. NP 4 started the resident on quetiapine at that time (2024). When they tried to decrease the dosage of the quetiapine, his falls increased. She was afraid he was going to fall and break something. Delusions were reported to her by staff. She did not have documentation of specific delusions or hallucinations. The most recent GDR was initiated by hospice. The last time she saw Resident 12 was on 10/14/25 and at that point, he was on 25 mg quetiapine at 2:00 p.m. and 9:00 p.m. During an interview with LPN 6 on 5/7/26 at 11:44 a.m., she indicated Resident 12 would kick-box during care. His movements were controlled. He would talk randomly and called out to people who were not in the room. He did not use full sentences. He reached out with his hands as if doing something, even trying to eat when nothing was in his hand. She considered those behaviors to be delusions or hallucinations. He was trying to do something with his hands that was not there to do. He would sometimes instruct staff on how to help him with his task. During an interview with the MDS Coordinator on 5/7/26 at 2:59 p.m., she indicated Resident 12 had delusions where he would pull himself up to the wall and fidget with something unseen. His wife brought in a busy board so he could fidget with something. She thought he believed whatever was on the wall was real. The resident's ability to speak waxed and waned from day to day. Some days, he (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could talk and respond appropriately. Other days, his speech was nonsensical. She questioned if the antipsychotic (not quetiapine) he was given during his hospitalization, prior to his admittance to the facility, might have caused some of his initial problems. During an interview with the DON on 5/7/26 at 2:59 p.m., she indicated Resident 12 would sometimes end up on the floor during his delusions. If staff tried to redirect him, or get him off the floor, he would become agitated because he was working on his job. Resident 12's family wanted him to stay as independent as possible. The facility tried to find common ground with the family and tried different medications. One medication they put him on completely snowed the resident (unresponsive, drooling). The goal was to help him remain active, not snowed. He was currently on the quetiapine because of his restlessness and agitation. The restlessness and agitation resulted in falls, typically at nighttime. She thought the delusions were what caused him to try to get up. Resident 12 did not say things like, Did you see that man over there? Rather, when he would fidget with an unseen object, he would say I need to fix this. Because he was (previously) very active, he liked to propel himself in his wheelchair, but he would fall out of the chair. His restlessness in bed caused multiple falls. A current facility policy, titled Use of Psychotropic Medications, provided by the Administrator on 5/7/26 at 4:30 p.m., indicated the following: .It is the intent of this policy to ensure that residents only receive psychotropic medications when other non-pharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.Adequate Indications for Use - refers to identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for us is inadequate. Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review of articles that are published in medical and/or pharmacy journals.Chemical Restraint - refers to any drug used for discipline or that makes it more convenient (less effort) for staff to care for a resident, and not required to treat medical symptoms. This includes instances when a psychotropic medication may be approved to treat certain symptoms, however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health and safety. 410 IAC (Indiana Administrative Code) 16.2 - 3.1-3(w)