STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195560	A. BUILDING _____ B. WING _____	**07/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUMMIT (THE)	**2200 MEMORIAL DRIVE ALEXANDRIA, LA 71301**

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 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 record review, policy review, and interview, the facility failed to ensure a reportable incident was reported to the State Agency for 1(#2) of 5 residents reviewed for incidents. According to the Resident Census and Conditions of Resident reported 06/29/2020, the facility census was 120 residents. Review of the facility's Incident Investigation and Reporting Policy and Procedure revealed incidents that involve injury of unknown origin but have no suspicion or allegation of abuse or neglect, elopements, or other unusual occurrence/adverse events shall be reported to the State Agency per state guidelines within 24 hours. Review of the Incident and Accident Report dated 05/15/2020 at 11:00 a.m. revealed resident #2 was being transported by the facility van for her [MEDICAL TREATMENT] appointment. S6 Transportation driver reported the resident was buckled in properly. The resident slid from under the seat belt to the van floor on her knees. The resident reported she was not injured and was able to move all extremities. The resident was assessed for injuries per EMT's and facility staff. Interview with S6 Transportation driver on 07/1/2020 at 11:30 a.m. revealed she had buckled the resident's seat belt at the waist and across her shoulder prior to leaving the facility. She revealed when she looked in the rear view mirror, she noticed the resident had slid down just a little in the wheelchair. She stated she asked the resident if she was okay and the resident stated yes. S6 Transportation driver revealed she kept looking back at the resident in the rearview mirror. She revealed she was almost at the [MEDICAL TREATMENT] center when she looked in the mirror and could not see the resident's head and she asked the resident if she was okay and the resident stated no. S6 Transportation driver revealed she pulled over to the side of the road, put the van flashers on, went to the back of the van and saw that the resident had slid partially out of the wheelchair. She revealed the resident was sitting on the foot rest of the wheelchair, with one knee bent underneath her and the seat belt underneath her breasts. She stated she immediately released the seat belt and the resident slid to the floor. She stated she assisted the resident off her knee to a sitting position on the floor. She stated she called 911 and the facility immediately. She stated she knew she could not get the resident up from the floor by herself. She stated EMS arrived and assisted with putting the resident back into her wheelchair and assessed her. No issues were noted. S6 Transportation driver revealed the facility staff arrived shortly after and assessed the resident and S7 CNA rode with her to the [MEDICAL TREATMENT] center and brought the resident another pair of pants to prevent her from sliding again. Interview with S8 RN on 07/1/2020 at 11:40 a.m. revealed on 05/15/2020 after receiving a call from S6 Transportation driver, she, S9 LPN and S7 CNA left the facility to go and assess the resident. S8 RN stated that when they arrived EMS had already departed and the resident was sitting up in her wheelchair and was secured with both lap and shoulder straps. She stated she assessed the resident and there was no redness, swelling or skin injuries. She stated the resident revealed she was fine and was not in any pain or discomfort. Interview with S9 LPN on 07/1/2020 who was also in the room at that time, confirmed the account of events given by S8 RN. Review of the EMT report dated 05/15/2020 revealed S10 EMT and S11 EMT at 11:04 a.m. assessed the resident, with no abnormal findings noted in the summary report. Resident's position was sitting, vital signs taken, and resident assessed to have had no pain. Interview with S10 EMT on 07/1/2020 at 1:45 p.m., revealed when she arrived at the scene, the resident was sitting on the floor of the van. She revealed the resident told them that she slid out of her chair and out from under her seat belt and that the seat belt was caught around the breast area by the lap seatbelt until S6 CNA removed it. She confirmed the wheelchair was in the upright position and was secured upon her arrival. She revealed the resident did not report that the wheelchair had fallen over, but she had slipped out due to her silky pajamas. She revealed, she and her work partner assisted the resident back into the wheelchair and secured her in. She stated the resident had no complaints of pain or of an injury. Interview with S5 Corporate Nurse on 07/1/2020 at 2:00 p.m. confirmed the incident should have been reported into SIMS, but was not.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct and complete a comprehensive assessment within 14 days of admission for 1 (#3) of 5 (#1, #2, #3, #4, and #5) sampled residents. The facility census was 120 according to the Resident Census and Conditions of Residents form dated 06/29/2020. Findings: Review of the resident's face sheet revealed an admitted [DATE] with [DIAGNOSES REDACTED]. Review of the residents' MDS assessments on 07/01/2020 at 2:00 p.m. revealed an open 5 day assessment with an ARD of 06/15/2020, and an open admission assessment with an ARD date of 06/15/2020. Further review revealed that assessments for sections C, D, G, GG, H, I, L, N, O, and P were not completed in either of the assessment entries. Interview on 07/01/1010 at 2:44 p.m. with S5 Corporate RN revealed the residents' comprehensive admission assessment had not been completed and should have been.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an RN wound assessment accurately reflected a resident's wound status for 2 (#1 and #5) of 5 (#1, #2, #3, #4, and #5) sampled residents with skin impairments. The facility census was 120 according to the Resident Census and Conditions of Residents form dated 06/29/2020. Findings: Review of the facility policy titled: Weekly Wound Documentation revealed in part Indicate the type of skin issue, Indicate the wound location, Answer all questions as applicable on the form, The form should be completed at least weekly (no longer than 7 days) and as appropriate until healed. 1. Review of resident #1's face sheet revealed a readmitted [DATE] with [DIAGNOSES REDACTED]. Review of a wound assessment report dated 04/28/2020 revealed the resident had a right foot ulcer that measured 2.00 cm x 1.50 cm x 0.20 cm. Further review revealed the wound bed contained 50% granulation and 50% slough tissue. The wound status was documented as unchanged. Review of a wound assessment report dated 05/05/2020 revealed the right foot ulcer measured 2.00 cm x 1.50 cm x 0.20 cm. Further review revealed the wound bed contained 100% slough tissue. The wound status was documented as unchanged. Review of the wound assessment narrative note dated 05/05/2020 revealed there was tendon and slight bone exposure. Review of a wound assessment report dated 05/12/2020 revealed the right foot ulcer measured 2.00 cm x 1.50 cm x 0.30 cm. Further review revealed the wound bed contained 75% granulation and 25% slough tissue. The wound status was documented as unchanged. Review of the wound assessment narrative note dated 05/12/2020 revealed the wound had 50% slough and 50% granulation tissue probing to bone. Review of a wound assessment report dated 05/19/2020 revealed the right foot ulcer measured 1.80 cm x 1.30 cm x 0.20 cm. Further review revealed the wound bed contained 75% granulation and 25% slough tissue. The wound status was documented as unchanged. Review of the record

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

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.

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F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) revealed the resident was out of facility 05/26/2020-06/01/2020. Review of a wound assessment report dated 06/02/2020 revealed the right foot ulcer measured 2.00 cm x 1.50 cm x 0.20 cm. Further review revealed the wound bed contained 100% slough tissue. The wound status was documented as unchanged. Review of wound assessment report dated 06/09/2020 revealed the right foot ulcer measured 2.00 cm x 1.40 cm x 0.10 cm. Further review revealed the wound bed contained 100% [MEDICATION NAME] tissue. The wound status was documented as unchanged. The wound assessment was also noted to be unsigned with no accompanying narrative note. Interview on 07/01/2020 at 12:37 p.m. with S3 RN/Treatment Nurse revealed that she had not completed the residents wound assessment due on 06/09/202. She confirmed that the last complete wound assessment was done on 06/02/2020 before the resident was hosptalized on [DATE]. She further stated that the status of the residents wound changed almost daily and confirmed that the wound status on the residents wound assessment reports were not accurately updated weekly with the assessments for 05/05/2020, 05/12/2020, and 06/02/2020 and should have been. Interview with S2 DON on 07/01/2020 at 12:41 p.m. confirmed the residents weekly wound assessment due on 06/09/2020 had not been completed. 2. Review of resident #5's Face Sheet revealed a readmitted [DATE] with [DIAGNOSES REDACTED]. Review of an Admission Wound Assessment report dated 03/23/2020 revealed the resident returned to the facility on [DATE] with an Unstageable pressure ulcer to her sacrum measuring: 10.00 cm x 12.00 cm x 0.50 cm. Further review revealed the wound bed contained 25% granulation and 75% slough tissue. Review of the wound assessment narrative notes dated 03/23/2020 revealed an I&D had been performed in the hospital on a pressure ulcer on the residents left buttock with an underlying abscess. The area had also been debrided during the hospitalization and the area extended across the residents' bilateral buttocks. Review of a wound assessment report dated 03/31/2020 revealed the residents' sacral ulcer was unstageable due to slough/eschar and measured 6.50 cm x 10.00 cm x 0.30 cm. Further review revealed the wound bed was documented as containing 75% granulation and 25% slough tissue. Review of a wound assessment report dated 04/07/2020 revealed the residents' sacral ulcer pressure ulcer was unstageable due to slough/eschar and measured 4.50 cm x 7.50 cm x 0.30 cm. Further review revealed the wound bed was documented as containing 75% granulation and 25% slough tissue. Review of a narrative wound assessment note dated 04/07/2020 revealed an unstageable sacral ulcer extended across the residents' bilateral buttocks with 100% granulation. Review of a wound assessment report dated 4/21/2020 revealed the residents' sacral ulcer was unstageable due to slough/eschar and measured 4.00 cm x 7.00 cm x 0.20 cm. Further review revealed the wound bed was documented as containing 100% granulation tissue. Interview on 06/30/2020 at 11:50 a.m. with S3 RN Treatment Nurse revealed the documentation of resident #5's sacral ulcer done on 04/07/2020 and 04/21/2020 did not accurately reflect the condition of the wound. She confirmed that on 04/07/2020 she documented the wound as unstageable due to slough/eschar in one area of the wound report and then documented the wound as having 100% granulation in her narrative note for that assessment. She further stated that wound stage on 04/21/2020 was inaccurate and should have been a Stage 3 and not Unstageable due to slough/eschar as she documented on the report and she confirmed that her narrative note indicated the wound had 100% granulation tissue.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive care plan within 21 days of admission for 1 (#3) of 5 (#1, #2, #3, #4, and #5) sampled residents. The facility census was 120 according to the Resident Census and Conditions of Residents form dated 06/29/2020. Findings: Review of the resident's face sheet revealed an admitted [DATE] with [DIAGNOSES REDACTED]. A copy of the Comprehensive Care plan was requested on 06/30/2020 which revealed the resident had only been care planned for the following problems: Resident at risk for psychosocial well-being concern related to medically imposed restrictions related to COVID -19. Resident has a wander/elopement alarm. Resident has a [DIAGNOSES REDACTED]. Interview on 07/01/1010 at 2:44 p.m. with S5 Corporate RN revealed the residents' comprehensive assessment had not been completed timely therefore, the care plan had not been completed and should have been.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to review and revise the care plan to include an unstageable pressure ulcer after a resident's return from the hospital and failed to revise the plan of care to reflect a resident's safe smoking status for 2 (#1 and #5) for 5 (#1, #2, #3, #4, and #5) sampled residents. The facility census was 120 according to the Resident Census and Conditions of Residents form dated 06/29/2020. Findings: 1. Review of the Care Plan for resident #1 revealed the following: Potential for harm d/t smoking, resident is a safe smoker. 04/18/2018-resident currently not a safe smoker. Found her in room smoking. Review of resident #1's Smoking Screens dated: 02/25/2020, 03/15/2020, and 06/01/2020 revealed the resident safely smoked independently. Interview on 06/30/2020 at 2:38 p.m. with S5 Corporate Nurse revealed that resident's smoking assessments were completed quarterly and as needed if there were changes in the residents' status. S5 Corporate Nurse confirmed that the residents care plan should have been revised to indicate that she was a safe smoker and had not been. 2. Review of the Admission Wound Assessment report dated 03/23/2020 for resident #5 revealed the resident returned to the facility on [DATE] with an unstageable pressure ulcer to her sacrum measuring 10.00 cm x 12.00 cm x 0.50 cm. The wound bed was noted to contain 25% granulation and 75% slough tissue. Review of resident #5's care plan revealed no documentation regarding the residents' unstageable pressure ulcer. Review of section H., number 5, of the facility's policy titled: Pressure Ulcer Prevention and Treatment Interventions Guidelines revealed the care plan is to be evaluated and revised based on the response, outcomes, and needs of the resident. Interview on 06/30/2020 at 10:40 a.m. with S2 DON revealed that the care plan provided was the most recent. S2 DON confirmed that resident #5 was not care planned for the unstageable sacral wound after she returned from the hospital on [DATE] and should have been.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident received treatment and care of abdominal wounds in accordance with professional standards of practice for 1 (#2) of 4 residents identified with wounds (#2, #3, #4 and #5), in a total sample of 5 residents (#1, #2, #3, #4 and #5). This deficient practice resulted in actual harm for resident #2 who had [DIAGNOSES REDACTED]. The bilateral abdominal nodules ulcerated into open wounds on 06/03/2020. The physician was notified; however, wound care orders were never obtained. From 06/03/2020 to 06/23/2020, wound care was performed daily to the areas without orders from the physician. The abdominal wounds were not assessed weekly after 06/03/2020 as per policy and procedure. The resident's open wounds worsened, and the resident was sent to a hospital on [DATE] with a large open abdominal wound approximately 4 cm x 6 cm, malodorous discharge with black surrounding tissue. The abdominal wound was surgically debrided on 6/26/2020. Findings: Review of the Weekly Wound Documentation Policy and Procedure revealed weekly wound documentation should be completed immediately upon identification of a skin issue. The documentation shall be completed using Wound/Skin Management Documentation Record for non-electronic documentation or the Wound Assessment Manager (WAM) for electronic documentation. Documentation should indicate the type of skin issue, the wound location, answer all the questions as applicable on the form, the form should be completed at least weekly (no longer than 7 days) and as appropriate until healed and once the wound has healed, indicate resolved. Review of resident #2's medical record revealed she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. On 5/2/2020 the resident returned to the facility with new [DIAGNOSES REDACTED]. Further review of the resident's record revealed the resident was admitted to the hosptial on 6/23/2020 and was currently in the hospital. Review of the MDS assessment dated [DATE] revealed the resident was assessed to have a BIMS of 15. The MDS also revealed the resident required extensive assistance of one person with bed mobility, transfers, walking in room, dressing, toileting and personal hygiene. She was also assessed to be severely visually impaired. Review of the Resident's Care Plan revealed an update on 06/03/2020 that addressed the resident's Skin was at risk for Impairment [MEDICAL CONDITION] (nodules) to the left lower and right lower

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) abdomen. However, the care plan was not updated to include interventions/treatments for the open wounds to the bilateral abdominal areas. Review of the Wound Assessment Report dated 6/3/2020 and documented by S3 RN/Tx Nurse revealed the following: a new wound to the left lower quadrant was identified. The cause of the wound was unknown, the wound had serous, scant drainage, the wound bed was 25% slough and 75% eschar and measured 5 cm X 5 cm X .10 cm. Review of the narrative for the above dated report revealed the [DIAGNOSES REDACTED] nodule to the left side of the abdomen was now open and the lesion measured 5 cm X 5 cm X 0.1 cm with 75% eschar and 25% slough. The eschar was moist and gray in color with an odor noted. The hand size nodule remained tender and dark in color. The Physician and RP were notified; however, there were no physician orders for treatment of [REDACTED]. Review of the Wound Assessment Report dated 6/3/2020 revealed the following: a new wound to the right lower quadrant was identified. The cause of the wound was unknown, the wound had serous, scant drainage, the wound bed was 100% eschar and measured 5 cm X 4 cm X .10 cm. Review of the narrative for the above dated report revealed the [DIAGNOSES REDACTED] nodule to the right side of the abdomen was now open and the lesion measured 5 cm X 4 cm X 0.1 cm with 100% eschar. The eschar was moist and gray in color with an odor noted. The hand size nodule remained tender and dark in color. The Physician and RP were notified; however, there were no physician orders for treatment of [REDACTED]. Review of the June, 2020 eTARs revealed, a treatment to monitor nodules to bilateral sides of abdominal fold every day until resolved with a start date of 3/24/2020. There was no documentation on the eTARs regarding the change in the abdominal wound status from nodules to open wounds after they were identified on 06/03/2020. Further review of the eTARS from 6/3/2020 to 6/22/2020 revealed staff initials that the abdominal nodules were monitored. Interview with S3 RN/Tx Nurse on 6/30/2020 at 2:00 p.m. revealed on 6/3/2020 she was informed that the nodules to the resident's right and left lower abdominal quadrants were open wounds. She stated she assessed the wounds, cleaned the wounds with NS and put a border gauze over the wounds at that time. She stated she notified the resident's primary physician of her findings on 6/3/2020. S3 RN Tx Nurse also stated that the physician said he needed to consult with [MEDICAL TREATMENT] in order to develop a treatment plan. S3 Tx Nurse stated she went on sick leave on 6/9/2020 to 6/25/2020, and did not follow-up and consult with the physician regarding wound care orders, or notify the family of the resident's abdominal wounds status on 06/3/2020, and prior to 6/9/2020. Interview with S4 RN on 7/6/2020 at 9:28 a.m. revealed she was assigned to provide treatments to resident #2 on 6/13/2020. She stated the right abdominal wound was draining a moderate amount of drainage that had a foul odor, the tissue to the wound bed was grayish in color, and she packed the wound with 2-3 gauze 4x4s and treated the wound with Dakins' solution. She revealed she had not measured the right abdominal wound. Further interview with S4 RN on the above date and time, revealed the left lesion was approximately 2 cm X 2 cm and did not require packing. She stated she treated the left abdominal wound with Dakins solution as well. S4 RN confirmed she had not called the physician to obtain orders to treat the wounds with Dakins solution, but instead contacted the S3 Tx Nurse RN (who was on sick leave) and they both decided to treat the abdominal wounds with Dakins solution. S4 RN confirmed she had not contacted the physician to inform him that the bilateral abdominal wounds drainage had a foul odor and the wound required packing. Interview with S2 RN/DON on 07/06/2020 at 9:30 a.m. revealed she performed wound care to the resident's abdominal wounds by cleaning the wounds with NS and covering with 4 x 4 gauze on 6/14, 6/17, 6/18, 6/21 and 6/22/2020. She confirmed there were no orders for the treatment of [REDACTED]. S2 RN/DON was unable to describe the wounds, other than to state it was grayish in color. S2 RN/DON confirmed the last time a Wound Assessment was documented was on 6/3/2020. She confirmed there should have been weekly wound assessments completed and there were not. She also confirmed there were no physician treatment orders obtained for the abdominal wounds that were identified on 6/3/2020. S2 RN/DON confirmed there was no follow-up with the physician for wound treatment orders after 6/3/2020, but there should have been. Further review of the June, 2020 eTARS revealed from 06/04/2020 to 06/12/2020, 6/15/2020, 6/16/2020, 6/19/2020 and 6/20/2020, the eTARS had been initialed that the abdominal nodules were monitored. However, according to the S3 RN's treatment notes dated 06/03/2020, and interview of S3 RN Treatment nurse on 06/30/2020 at 2:00 p.m., the abdominal nodules had ulcerated into open wounds. There was no documentation in the resident's medical record that revealed the opened abdominal wounds were assessed on the above dates, or that treatments had been provided to the bilateral abdominal open wounds. S2 RN/DON revealed in an interview on 07/06/2020 at 9:30 a.m. that she had delegated the wound treatments to staff as much as possible, and they were doing the best they could. S2 RN/DON confirmed there was no documentation of assessments or treatments to the open wounds after 06/03/3030 to the time the resident was admitted to the hospital on [DATE]. The surveyor was unsuccessful in attempts to interview staff that initialed the eTAR on the above dates. Review of the hospital H&P dated 6/23/2020 revealed the resident was admitted with [DIAGNOSES REDACTED]. Treatment plan included to start on [MEDICATION NAME] and [MEDICATION NAME], CT of abdomen/pelvis with PO and IV contrast, Consult wound care and Surgery Consult. Interview with the resident's RP on 6/30/2020 at 10:00 a.m. revealed the resident had a large necrotic wound to the right side of her abdomen that was open and draining foul smelling drainage and required debridement on 6/24/2020.