

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195560	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER The Summit		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a Resident fed by enteral means received the appropriate treatment and services for 1 (#3) of 3 Sampled Residents. The facility failed to ensure the resident's tube feeding was administered per the physician orders. Findings: Record Review revealed Resident #3 was admitted to the facility on [DATE] and had diagnoses that included in part. Chronic Obstructive Pulmonary Disease, Cerebral Infarction, Aphasia following CVA (Cerebral Vascular Attack), Hemiplegia and Hemiparesis following CVA affecting right dominant side, Abnormal Weight Loss, Pressure Ulcer of Sacral Region-Stage 2, Pressure Ulcer of Right Hip- Stage 2, and Pressure Induced Deep Tissue damage of Left ankle and Left Heel. Review of Resident #3's Quarterly MDS with an ARD of 01/20/2026 revealed Resident #3 BIMS was not assessed due to memory problem. Resident #3 was dependent on staff for eating. Resident #3 had a feeding tube. Review of Resident #3's Comprehensive Person Centered Care Plan with target completion date of 04/23/2026 revealed in part. Resident #3 received tube feeding; Fibersource at 60 ml/hr. Review of Resident #3's Current 02/2026 Physician Orders read in part. Enteral Feed, Fibersource @ 60ml/hr. Start date 02/17/2026. Review of Resident #3's 02/2026 EMAR read in part. Enteral Feed Order, every shift tube feeding formula Fibersource at 55 ml/hr. Start Date-11/11/2025. Discontinued Date- 02/17/2026. Enteral Feed Order, every shift tube feeding formula Fibersource at 60 ml/hr. Start Date-02/17/2026. Review of Resident #3's Departmental Progress notes read in part. 02/17/2026 1:44 p.m. S3RD documented; Recommendation: Increase tube feed to Fibersource @ 60 ml/hr. 02/17/2026 3:48 p.m. S1DON documented; Resident #3 with new order to increase tube feed to Fibersource @ 60ml/hr. Observation on 02/23/2026 at 10:45 a.m. revealed Resident #3 received tube feeding of Fibersource at 55ml/hr. via pump. Observation on 02/23/2026 at 4:08 p.m. revealed Resident #3 continued to receive tube feeding of Fibersource at 55ml/hr. via pump. Observation on 02/24/2026 at 8:25 a.m. revealed Resident #3 received tube feeding of Fibersource at 55ml/hr. via pump. Observation on 02/24/2026 at 12:25 p.m. revealed Resident #3 continued to receive tube feeding of Fibersource at 55ml/hr. via pump. Interview on 02/24/2026 at 12:50 p.m. with S2LPN, and observation of Resident #3's set tube feed rate. S2LPN confirmed Resident #3 tube feeding was infusing at 55ml/hr., but should be at 60ml/hr.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 195560	Facility ID: 195560 If continuation sheet Page 1 of 1