STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195560	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Summit	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview the facility failed to provide care and services that met professional standards of quality by failing to ensure Physician's Orders were implemented for 2 (Resident #1 & Resident #3) of 3 sampled residents. Findings:Review of a policy titled Physician Orders with a revision date of 09/2025 read in part. It is the policy of this facility that all physician orders shall be implemented timely and carried out in a professional manner. Resident #1Review of Resident #1's medical record revealed an admission date of 01/10/2023, with diagnoses that included in part.Moderate Protein- Calorie Malnutrition, Atrial Fibrillation, Type 2 Diabetes with Diabetic Neuropathy, Dementia, Schizophrenia, Major Depressive Disorder, and Essential Hypertension. Review of Resident #1's MDS with an ARD of 05/12/2026 revealed Resident #1 has a BIMS score of 3, indicating severe cognitive impairment. Resident #1 required substantial/ maximum assistance with ADLs. Review of Resident #1's laboratory results, which included a written physician's order dated 01/14/2026, read in part. increase oral fluid intake by 500 ml three times daily for three days. Review of the laboratory results revealed S3LPN acknowledged receipt of the physician's order by signature. On 06/23/2026 at 1:29 p.m., an interview with S3LPN confirmed there was no documentation indicating the physician's order dated 01/14/2026 to increase Resident #1's oral fluid intake had been implemented. On 06/24/2026 at 9:41 a.m., an interview with S5MedicalRecords confirmed there was no documentation in Resident #1's medical record indicating the physician's order dated 01/14/2026 to increase oral fluid intake had been implemented. On 06/24/2026 at 11:09 a.m., an interview with S4NP revealed that verbal and written physician orders are expected to be implemented by facility nursing staff. On 06/24/2026 at 2:30 p.m., an interview with S1CorporateRN confirmed there was no documentation indicating the physician's order dated 01/14/2026 to increase Resident #1's oral fluid intake had been implemented and documented in the resident's medical record, but should have been. Resident #3Review of Resident #3's medical record revealed an admission date of 05/24/2024, with diagnoses that included in part. Chronic Obstructive Pulmonary Disease, Alzheimer's Disease, Dementia, Anxiety, Essential Hypertension, and Diabetes Mellitus. Review of Resident #3's MDS with an ARD of 05/18/2026 revealed Resident #3 has a BIMS score of 3, indicating severe cognitive impairment. Resident #3 was dependent on staff for all ADLs. Review of Resident #3's comprehensive care plan, with a revision date of 06/09/2026, read in part. Resident #3 had the potential for abnormal laboratory values related to the diagnosis of anemia. Care plan interventions included monitoring laboratory results as ordered. Review of Resident #3's laboratory results revealed a written physician's order dated 05/14/2026 which read in part. follow up with a complete blood count (CBC) in four weeks. On 06/24/2026 at 1:47 p.m., an interview with S5MedicalRecords confirmed the physician's order for a repeat CBC was not completed as ordered. On 06/24/2026 at 2:30 p.m., S1CorporateRN confirmed that the laboratory test was not completed as ordered by the physician, but should have been.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195560	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Summit	2200 Memorial Drive Alexandria, LA 71301

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and an interview, the facility failed to ensure a resident's medical record was accurately documented in accordance with accepted professional standards and practices. The facility failed to ensure activities of daily living tasks performed were accurately documented for 1 (Resident #1) of 3 sampled residents. Findings: Review of a policy titled Documentation with a revision date of 03/2026 read in part.Clinical Record Accuracy: It is the policy of this facility to maintain accurate, complete and timely clinical records in accordance with the regulatory requirements. Review of Resident #1's medical record revealed an admission date of 01/10/2023, with diagnoses that included in part.Moderate Protein- Calorie Malnutrition, Atrial Fibrillation, Type 2 Diabetes with Diabetic Neuropathy, Dementia, Schizophrenia, Major Depressive Disorder, and Essential Hypertension. Review of Resident #1's MDS with an ARD of 05/12/2026 revealed Resident #1 has a BIMS score of 3, indicating severe cognitive impairment. Resident #1 required substantial/ maximum assistance with ADLs. Review of a nursing progress note dated 05/20/2026, documented by S3LPN, read in part. Resident #1 was not feeling well and did not eat lunch. Review of the facility's meal intake documentation revealed that, for lunch on 05/20/2026, Resident #1 was documented as having consumed 100% of the meal. On 06/23/2026 at 1:29 p.m., S3LPN confirmed that Resident #1 did not consume lunch on 05/20/2026. S3LPN further acknowledged that the meal intake documentation indicating Resident #1 consumed 100% of the meal intake was inaccurate and did not reflect the resident's actual intake. Review of the facility tasks titled, Offer resident fluids every 2 hours while awake, revealed documentation indicating that staff offered Resident #1 fluids on 05/21/2026. Review of the medical record revealed Resident #1 was hospitalized on [DATE] and was not present in the facility. On 06/23/2026 at 4:35 p.m., S2DON acknowledged that the documentation regarding Resident #1's meal intake on 05/20/2026 was inaccurate. S2DON confirmed documentation should have accurately reflected Resident #1's actual meal consumption, but did not. S2DON also acknowledged that documentation indicated staff offered Resident #1 fluids on 05/21/2026. S2DON confirmed Resident #1 was hospitalized at that time and confirmed documentation was inaccurate.