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	04/08/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs and preferences for 1 (#6) of 2 (#6, #102) residents reviewed for environment. The facility failed to ensure Resident #6 had a call light in reach in order to call for assistance. Total sample size: 41 residents. Findings: Review of a policy titled Call Light/Bell with a revision date of 01/2024 read in part.Purpose:1. To provide the resident a means of communication with staff members.Procedure:7. Leave the resident comfortable. Place the call light within the resident's reach before leaving the room. Review of Resident #6's medical record revealed an admit date of 10/14/2025 with diagnoses that included in part: Cerebral Infarction due to Unspecified Occlusion or Stenosis of Left Cerebellar Artery, Diabetes, Cardiomyopathy, Paroxysmal Atrial Fibrillation, Intervertebral Disc Displacement, and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side. Review of Resident #6's quarterly MDS with an ARD of 01/22/2026 revealed Resident #6 was dependent on staff for ADLs. A BIMS exam was not conducted on Resident #6 due to being rarely or never understood. Review of Resident #6's Care Plan dated 01/29/2026 read in part.Resident #6 was at risk for falls related to impaired mobility. Interventions included ensuring the call light was placed within reach. On 04/06/2026 at 10:32 a.m., observation revealed Resident #6 lying in bed with the call light not within reach. Further observation of the call light revealed it was not within reach due to insufficient cord length. On 04/07/2026 at 1:48 p.m., observation revealed Resident #6 sitting upright in a geri-chair in his room with the call light not within reach. Further observation of the call light revealed it was not within reach due to insufficient cord length. Interview with Resident #6 revealed he was able to identify the call light as the device used to request assistance. Resident #6 stated I can't reach it most of the time, so I holler out for help. On 04/07/2026 at 1:56 p.m., accompanied by S4LPN to Resident #6's room. S4LPN confirmed that Resident #6's call light was not within reach. S4LPN further confirmed that the call light could not be reached by Resident #6 when in bed or seated in the geri-chair due to insufficient cord length. S4LPN confirmed Resident #6 is cognitively aware and able to appropriately use the call light when available. On 04/07/2026 at 2:00 p.m., accompanied by S1DON to Resident #6's room. S1DON confirmed Resident #6's call light was not within reach, but should have been.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the Ombudsman in writing of resident transfer/discharge for 1 (Resident #100) of 1 residents reviewed for transfer/discharge. The total sample size was 41. Findings:Review of a facility policy on 04/08/2026 at 10:11 a.m. titled, Discharge Transfer and Planning with a review date of 03/2026 revealed the following in part .Ombudsman Notification: The community shall notify the resident and the resident's representative(s) of the transfer or discharge via the Discharge/Transfer Notice, and the notices must be sent to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time or transfer or discharge except when an emergency transfer occurs. Review of Resident #100's medical record revealed an admission date of 01/09/2026 and a discharge date of 02/02/2026, which included diagnoses of Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Acute Respiratory Failure with Hypercapnia.Review of Resident #100's 02/2026 physician's orders revealed the following order .Discharge home with Home Health and medications on 02/02/2026 one time only. Review of Resident #100's 02/2026 nursing progress notes revealed the following in part .02/02/2026- Resident discharged home with home health.Review of Resident #100's Discharge Summary for 02/02/2026 revealed the following in part .Notes: discharged home to home/community with home health. Review of a facility report on 04/08/2026 at 9:36 a.m. titled, Louisiana Ombudsman Program/Emergency Transfer Log for 02/2026 revealed Resident #100's discharge on [DATE] was not included on the notification report. In an interview on 04/07/2026 at 4:27 p.m., S1 DON revealed Resident #100 admitted for therapy services and had a planned discharge home with home health in 02/2026.In an interview on 04/08/2026 at 9:31 a.m., S2 Accounts Manager revealed she was responsible for notification of transfers/discharges to the Louisiana Ombudsman Program. S2 Accounts Manager revealed she only submitted the emergency transfers to the Louisiana Ombudsman Program. S2 Accounts Manager revealed she was unaware to notify the Ombudsman of non-emergency transfer/discharges, such as a planned discharged , and confirmed Resident #100 discharge on [DATE] was not submitted to the Louisiana Ombudsman Program.

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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. Based on interview and record review, the facility failed to complete a Discharge Minimum Data Set (MDS) assessment within 14 days for 1 (Resident #56) of 1 sampled resident investigated for Resident Assessment.Findings:Review of resident #56's medical record revealed an admission date of 09/02/2025 and a discharged date of 02/11/2026. Further review of resident #56's medical record on 04/07/2026 revealed the Discharge Minimum Data Set (MDS) assessment had not been completed after the resident discharged on 02/11/2026. In an interview on 04/07/2026 at 3:09 p.m., S5 MDS LPN confirmed the discharge MDS assessment for resident #56 was not completed within the 14-day timeframe.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards. The facility failed to ensure respiratory equipment/Bi-PAP was stored properly for 1 (Resident #7) of 2 residents reviewed for respiratory care. The total sample size was 41 residents.Findings:Review of a facility policy on 04/08/2026 at 8:32 a.m. titled, CPAP/BiPAP Device review date of 01/2024 revealed in part .The manufacturer's policies and procedures will be followed for the use and care of this equipment. Review of Resident #7's medical record revealed an admission date of 01/13/2015 with diagnoses, which included in part . Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Obstructive Sleep Apnea (Adult), and Personal History of Transient Ischemic Attack (TIA). Review of Resident #7's Quarterly MDS with ARD of 01/20/2026 revealed a BIMS of 15, which indicated intact cognition and required use of a non-invasive mechanical ventilator (BiPAP). Review of Resident #7's 04/2026 physician orders revealed orders in part .-Remove BiPAP one time a day related to Obstructive sleep apnea (adult).Review of Resident #7's care plan with an initial date of 01/22/2026 revealed the following in part .Focus: Resident has sleep apnea. Interventions: BiPAP every night. During review of Resident #7's care plan revealed no evidence of refusal of the BiPAP or the resident taking his BiPAP mask off on his own. In an interview on 04/06/2026 at 8:31 a.m., Resident #7's revealed he used a BiPAP every evening for sleep apnea. Resident #7 revealed the nurse would apply the BiPAP mask before bedtime and would remove the mask in the morning after he woke up. Resident #7 was unsure if the nurse put the BiPAP mask in a storage bag after each use. Observation, at the time of interview, revealed Resident #7's BiPAP mask was not in use and placed directly on the resident's bedside dresser, unbagged and unlabeled. In an interview on 04/07/2026 at 7:41 a.m., Resident #7's revealed he used his BiPAP last night. Observation, at the time of interview, revealed Resident #7's BiPAP mask was not in use and placed directly on the resident's bedside dresser, unbagged and unlabeled. Observation on 04/07/2026 at 11:59 a.m. revealed Resident's #7's BiPAP mask was not in use and placed directly on the resident's bedside dresser, unbagged and unlabeled. In an interview on 04/07/2026 at 1:00 p.m., S3 LPN revealed she was assigned to Resident #7, and he required the use of a BiPAP at night. S3 LPN revealed the nurse on duty was responsible for application of the mask before bedtime and would remove the mask in the morning. S3 LPN revealed the nurse should clean the BiPAP mask and store it in a labeled bag, when not in use. S3 LPN revealed Resident #7 does not refuse his BiPAP or take the mask off on his own.On 04/07/2026 at 1:15 p.m., S3 LPN accompanied this surveyor to Resident #7's room. S3 LPN confirmed Resident #7's BiPAP mask was not in use and placed directly on the resident's bedside dresser, unbagged and unlabeled. S3 LPN confirmed Resident #7's BiPAP mask should have been properly stored and labeled in a bag, but was not.In an interview on 04/08/2026 at 9:18 a.m., S1 DON revealed when a resident's BiPAP was not in use, the BiPAP mask should be cleaned with soap and water and stored in a labeled bag. S1 DON confirmed that all nurses were aware to store a BiPAP mask in a labeled bag when not in use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview, the facility failed to provide pharmaceutical services to meet the needs of each resident as evidenced by having expired medications available for resident use for 2 (Resident #82 and Resident #89) residents. This had the potential to affect 88 residents who resided in the facility.Findings:Review of the revised policy dated 10/19 titled Destruction of Unused, Expired or Discontinued Medications revealed, in part, .All outdated, discontinued and/or recalled drugs, and all containers with illegible or no labels will be given to the Director of Nursing (DON) for proper disposition.In an interview with S7 LPN and observation of Cart #2 on 04/08/2026 at 9:37 a.m., revealed two expired medications, Resident #82's narcotic of Tramadol 50mg with an expiration date of 02/08/2026 and Resident #89's medication of Cyclobenzaprine 5mg with an expiration date of 01/29/26. S7 LPN confirmed both medications listed above were on the cart for use and expired but should not have been. In an interview on 04/08/2026 at 10:40 a.m., S1 DON confirmed S7 LPN had expired medications on Cart #2 that had not been properly disposed of but should have.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to: Ensure the Director of Nursing services and the infection preventionist attended the Quality Assessment & Assurance (QAA) committee's quarterly meeting; andConduct QAA meetings at least quarterly for the year of 2025. This had the potential to affect 88 residents who resided in the facility.Findings: Review of the facility's QAA committee meeting minutes for Quarter 1 of 2026 dated 03/23/2026 revealed the meeting's attendance signature sheet did not include the signature of the facility's Director of Nursing services or the infection preventionist. In an interview on 04/08/2026 at 3:15 p.m., S9 Administrator confirmed the Director of Nursing and the infection preventionist did not attend the QAA meeting for Quarter 1 of 2026 on 03/23/2026. In an interview on 04/08/2026 at 3:40 p.m., S9 Administrator acknowledged there was no QAA quarterly meeting minutes for Quarter 3 of 2025. S6 Collaborating Home Administrator confirmed the facility did not have QAA meeting minutes for Quarter 3 of 2025 but should have.