DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0398	A. BUILDING: _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT POINTE SENIOR LIVING	3505 ENGLISH GLEN AVENUE MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 87 Number of tenants with cognitive impairment: 1 Total census: 88 No regulatory insufficiencies were cited during the investigation into Complaint #119810-C. The following regulatory insufficiencies were cited during the investigation into Complaint #121428-C and Incident #121491-I:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to follow established procedure regarding discharge as stated in the occupancy agreement for 1 of 3 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 8/5/24 revealed Tenant C1 had an Occupancy Agreement signed by Tenant C1's spouse on 8/13/23 with notation of the spouse as the Power of Attorney. Section III of the Occupancy Agreement entitled "Termination Procedures" notated: Under certain circumstances, a significant change in the	A 150		

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Tenant's condition may result in the need for the provision of services which exceed the type or level of services allowed by law in an Assisted Living Program or permitted pursuant to the Occupancy Agreement. In those circumstances, the Program will provide written notice to the Tenant of the need for discharge and the reason for the discharge.

Tenant C1 was evaluated on 4/17/24 at the hospital with a chief complaint of new back pain. An X-ray of the thoracic spine was notable for severe T12 compression fracture. Tenant C1 was admitted to the hospital.

A progress note dated 5/8/24 revealed the program received a message from the social worker at the hospital informing them Tenant C1 may be ready for discharge the following week and requested program staff complete an assessment to determine if she was eligible to return.

A late entry progress note dated 5/10/24 indicated the tenant was discharged and would be going to long term care.

During an interview on 8/6/24 at 9:00 AM, the Marketing Director stated she was unsure if the Nursing Director did an assessment of Tenant C1. When requested, the program could provide no documentation an assessment was completed by the nurse.

A review of an undated summary statement from the Marketing Director revealed she met with Tenant C1's spouse/power of attorney on 5/9/24. The Marketing Director identified level of care concerns with Tenant C1, but stated it would depend upon the results of assessment

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A 150	Continued From page 2 performed by the nurse, scheduled for 5/10/24. A decision regarding Tenant C1's return to the program would be made by the team following the assessment. The summary note indicated representatives of Tenant C1 were informed on 5/13/24 by staff at the hospital Tenant C1 was not able to return to the program. On 8/5/24 at 8:56 AM, the Executive Director said there was no policy on Admission & Discharge and the Program's Admission and Discharge procedures were provided in the Occupancy Agreement. The Executive Director confirmed Tenant C1 was not provided with a written discharge notice.	A 150		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review, staff failed to follow the training provided when caring for 1 of 3 discharged tenants reviewed (Tenant C1). Findings include: 1. Record review on 8/5/24 revealed an Incident Report dated 4/14/24 describing a fall experienced by Tenant C1. The Care Coordinator walked with Tenant C1 to the shower.	A 361		

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The Care Coordinator turned to open the shower curtain when Tenant C1 stopped, said "I can't" and fell straight back onto the floor. Tenant C1 hit her head on a spare shower chair and was unresponsive for about 30 seconds.

Tenant C1's service plan, dated 4/10/24, identified she used a walker and staff were to provide an assist of 1 with transfers and ambulation. Due to her history of falls, staff were to keep the walkway clear of clutter.

On 8/6/24 at 9:45 AM, the Care Coordinator reported she assisted Tenant C1 to undress in preparation of the shower. Tenant C1 was ambulating with her walker with the Care Coordinator's assistance. The Care Coordinator turned away from Tenant C1 to pull back the shower curtain and removed her hands from the tenant. Tenant C1 then stopped walking, stated "I can't" and then immediately fell backwards to the floor, hitting her head on the spare shower chair in the bathroom. The Care Coordinator stated she normally would have had a gait belt on Tenant C1 when ambulating with her, but not when a tenant was undressed due to concerns with skin irritation.

During an interview on 8/6/24 10:40 AM Staff A stated if she were assisting a tenant who required an assist of 1 into the shower, she would have had the walker next to the person, had the tenant hang on to the shower grab bars while her hand was on the tenant's back helping to guide the tenant and offer reassurance so if the tenant were to fall she could easily help the tenant. She stated a gait belt couldn't be used on an unclothed tenant.

On 8/7/24 at 4:03 PM the Nurse Consultant

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stated when a tenant required assistance of 1 a gait belt should be utilized with transfers and ambulation.

The Nurse Delegation instructions for ambulating a tenant with a walker directed staff to do the following: When ambulating a tenant with a walker, staff were to utilize a gait belt, stand to the side and slightly behind the tenant and give support with both hands on the gait belt. When transferring a tenant, the delegation sheet instructed staff to utilize a gait belt.

When interviewed on 8/6/24 at 1:00 PM, the Nurse Case Manager stated she would expect staff to be with a tenant who was an assist of 1 at all times and to utilize a gait belt. The Nurse Case Manager stated an assist of 1 meant staff were to have hands-on the tenant. The Nurse Case Manager's expectation of staff assisting a tenant who required an assist of 1 into the shower was to use a gait belt but perhaps use a shirt or towel under the gait belt until the tenant was safely positioned in the shower.

2) A review of Tenant C1's Medication Administration Record (MAR) for April 2024 reflected new orders for Tramadol and Tylenol on 4/11/24. Staff documented on the MAR what medication was given, the severity of a tenant's pain along with the effectiveness of the medication. Tenant C1 received pain medication on the following dates for pain identified as a "10" on a 10 out of 10 pain scale:
- 4/12/24 at 2:57 PM (Tylenol administered, resolution effective)
- 4/14/24 at 1:05 PM (Tylenol administered, ineffective)
- 4/14/24 at 4:12 PM (Tramadol administered, ineffective)

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A 361	Continued From page 5 - 4/15/24 at 4:16 PM (Tramadol administered, ineffective) - 4/15/24 at 4:00 PM (Tylenol administered, effective) - 4/16/24 at 8:16 AM (Tramadol administered, effectiveness unknown) - 4/16/24 at 5:14 PM (Tylenol administered, effective) A progress note dated 4/14/24 at 1:53 PM revealed staff called the nurse and requested to send Tenant C1 out to the ER for evaluation. The staff member reported Tenant C1 was using her call light non-stop and the staff member couldn't give the tenant any more medication. The staff member reported Tenant C1 was in pain, possibly hip pain. Per the delegation training sheets, staff were instructed to notify a nurse when a tenant complained of severe pain. On 8/7/24 at 2:36 PM, the Executive Director reported staff notified a nurse of Tenant C1's pain on 4/14/24, but not on the other dates as required.	A 361		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by:	A 395		

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A 395	Continued From page 6 Based on interview and record review, the Program failed to ensure a service plan was individualized and addressed pain needs for 1 of 3 discharged tenants reviewed (Tenant C1). Findings follow: Record review of progress notes for Tenant C1 on 8/5/24 revealed emergency room (ER) visits on the following dates: 11/9/23: Tenant C1 went to the ER due to having difficulty going to the bathroom. She returned with a Foley catheter due to urine retention. 11/29/23: Tenant C1 called 911 to go to the ER because she was not feeling well. Tenant C1 was admitted to the hospital with a urinary tract infection (UTI). 12/7/23: Tenant C1 went to the ER due to abdominal pain of 10/10. Tenant C1 returned to the program the same day. 1/3/24: Tenant C1 went to the ER for complaints of bladder pain. She was treated and released. 1/5/24: Tenant C1 was admitted to the hospital for a UTI and discharged on 1/7/24. 2/21/24: Tenant C1 went to the hospital on 2/21/24 for abdominal pain. She returned to the program on 2/22/24. 3/19/24: Tenant C1 was admitted to the hospital for bactremia. She returned to the program on 4/11/24. Tenant C1 had a change of condition assessment dated 1/31/24 which indicated pain which she rated at 2/10. A further change of condition assessment completed on 4/10/24 noted Tenant C1 had pain on the left side and rated her pain at a 3/10. On 8/6/24 at 2:56 PM, the Care Coordinator stated Tenant C1 was always in pain. If Tenant C1 experienced extreme pain, the Care	A 395		

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A 395	Continued From page 7 Coordinator would ask Tenant C1 if she wanted to go to the hospital. On 8/7/24 at 11:45 AM, the Nurse Case Manager noted Tenant C1 regularly reported pain. The Executive Director commented even with a pain rating of 2 or 3, Tenant C1 would call the emergency medical technicians and want to go to the hospital. Tenant C1's spouse/power of attorney tried to discourage Tenant C1 from visiting the hospital. Tenant C1's service plans dated 1/31/24 and 4/10/24 did not identify Tenant C1's ongoing pain or frequent trips to the emergency room. On 8/8/24 at 11:35 AM, the Executive Director confirmed Tenant C1's service plan did not address her needs.	A 395		