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
	S0248	A. BUILDING: _____ B. WING _____	01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT POINTE SENIOR LIVING COMMUNITY	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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 10 Total Census of Assisted Living Program for People with Dementia: 12 The recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program resulted in the following regulatory insufficiency:	A 000		
A 026	481-67.4(5) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(5) When a tenant attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the Department as required regarding 1 of 1 tenants reviewed who had attempted suicide (Tenant #1). Findings follow: On 12-19-18 review of a Resident Incident/Accident Report dated 11-27-18 at 3:30 p.m. revealed staff entered Tenant #1's	A 026	Please see attached letter outlining the Plan of Corrections for Notification to the Department - Kate Stevens, RN [signature] Director of Nursing 1/24/19	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	S0248	A. BUILDING: _____ B. WING _____	01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT POINTE SENIOR LIVING COMMUNITY	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 026	Continued From page 1 bathroom. When staff attempted to pick up water glasses observed on the floor Tenant #1, who was sitting on the toilet, became upset and told them not to take the glasses as she was trying to kill herself by drinking lots of water. The tenant talked to a family member on the phone, then started walking laps in the memory care unit. She did not eat or drink anything at dinner. Later that evening, the tenant stated she had to use the restroom but was unable to walk without leaning heavily on staff. Staff called for assistance. Vital signs were taken and the Director of Nursing (DON) and family were notified. Shortly after taking her medications at approximately 8:15 p.m., the tenant vomited three times. Family took the tenant to the hospital. A service note dated 11-28-19 indicated Tenant #1 was taken to the emergency room (ER) by family on 11-27-18 at around 9:00 p.m. due to "sudden onset of nausea/vomiting and weakness..." Lab work completed in the ER indicated Tenant #1 was hyponatremic. Tenant #1 was given intravenous Zofran and notes indicated she had little recall of the earlier events. At approximately 3:15 p.m. Tenant #1 had an "acute suicidal ideation" when she told staff "I'm trying to kill myself by drinking water." Tenant #1 made the statement while seated on the toilet urinating and the water glasses (two plastic 16 ounce tumblers) were across the room out of reach. Tenant #1 reported she drank "about 10" glasses of water from the tumblers. Staff notified the DON and family after the statement was made. At approximately 6:00 to 6:15 p.m. they directed Tenant #1 to her apartment to use the bathroom and noticed Tenant #1 had trouble walking and required	A 026	Please see attached letter. Kate Stevens, RN Director of Nursing 1/24/19	

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 _____	01/03/2019

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 089	Continued From page 2 3. Review on 1-3-19 of Tenant #10's file revealed A Health and Functional Status Assessment dated 10-20-17 documenting Tenant #10 had received occupational therapy (OT) services regarding activities of daily living. Staff was to assist with bathing after OT was completed. The service plan dated 10-17-18 reflected Tenant #10 no longer received therapy services, all goals were met and Tenant #10 was discharged from OT. When interviewed on 1-3-19 at 3:00 p.m. the DON revealed Tenant #10 was discharged from PT/OT services in mid June of 2018 and staff did not assist Tenant #10 with bathing. Further record review revealed the service plan was not updated to reflect the discharge from PT/OT services to reflect the discharge from outside agency services when it occurred in mid June 2018.	A 089	Please see attached letter -Kate Stevens, RN _____, RN Director of Nursing 1/24/19	

✓ 2.1.19

January 24, 2019

Deb Dixon
Department of Inspections and Appeals
Lucas State Office building
321 East 12th Street
Des Moines, IA 50319

Dear Ms. Dixon

On behalf of Summit Pointe Senior Living, we respectfully submit our Plan of Correction outlining corrective measures for the regulatory insufficiencies dated January 16, 2019. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state law.

Program Notification to the Department

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - The department shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant attempts suicide, regardless of injury.
    - Tenant #1 no longer resides at Summit Pointe.

2. Measures taken to ensure the problem does not recur.
    - The nurse will be educated on regulatory requirements for Program Notification to the Department

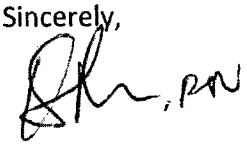
3. How the program plans to monitor performance to ensure compliance.
    - A sampling of tenant occurrence reports and charts will be audited by the nurse or designee for Summit Pointe at least once a quarter to ensure that the department was notified, if required, appropriately.

4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before February 15, 2019.

DD 1/28/19

Please feel free to contact Summit Pointe at 319-373-4242 with any questions you may have. Thank you.

Sincerely,



Kate Stevens, RN
Director of Nursing