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 _____	C 07/21/2020

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: 1 Number of tenants with cognitive disorder: 9 Total Census: 10 There were no regulatory insufficiencies cited during the onsite infection control survey completed at the time of the investigations. The following regulatory insufficiencies were cited during the investigations of Complaints 88817-C and 90650-C:	A 000	11/29/20	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 003	Plan of Correction is attached	

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

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A 003	Continued From page 1 Program failed to ensure the policy regarding the completion of incident reports was followed regarding 2 of 2 current tenants reviewed (Tenants #3 and #4). Findings follow: 1. On 7-20-20 at 10:07 a.m. Staff A revealed she had heard Tenant #3 had left the building in April and gone to the parking lot. Staff A was not working at the time of the incident. She was not sure of the date but it occurred on a weekend. On 7-20-20 at 10:51 a.m. Staff B revealed she had heard Tenant #3 had gone outside to the parking lot in April and tried to get into a car. Staff B was not working at the time of the incident. She said it occurred on a weekend. On 7-21-20 at 9:43 a.m. Staff C revealed she had heard Tenant #3 tried to get into a car she thought was hers in the parking lot in April. A co-worker said Tenant #3 was very determined to to get out into the car. A nurse came down and brought Tenant #3 back into the building. Staff C was not working at the time and said it occurred on the morning shift on a weekend. On 7-21-20 at 1:14 p.m. Staff D revealed months ago Tenant #3 had walked out of the building. Staff D was working on the general population side of the building. Staff D was not sure who was working in the memory care unit at the time. On 7-21-20 at 8:13 a.m. the Director of Nursing (DON) recalled on a Monday several months prior there was a discussion about Tenant #3 who left the building and was re-directed back. Staff was present when Tenant #3 left the building. The DON said the consultant company took care of the issue and she was not sure if an incident report was completed.	A 003		

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A 003	Continued From page 2 When interviewed on 7-15-20 at 4:08 p.m. the Executive Director revealed there were no incident reports for Tenant #3 from April to the present time. Record review on 7-14-20 and 7-15-20 of Tenant #3's file revealed she was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. 2. When interviewed on 7-21-20 at 8:13 a.m. the DON said Tenant #4 had displayed suicidal ideations to his family in June. Tenant #4's physician was contacted and a medication change occurred. He was placed on safety checks at night, his activity level was increased and one to one support was provided. The DON said she was not sure if an incident report was completed related to Tenant #4's suicidal ideations. Review of Tenant #4's file on 7-14-20 and 7-15-20 revealed he was staged at a four on the GDS, which indicated moderate cognitive decline. Progress notes dated 6-12-20 indicated Tenant #4 expressed suicidal ideations to family. The file contained no incident reports for the tenant. On 7-15-20 at 4:08 p.m. the Executive Director revealed there were no incident reports for Tenant #4 in the time period requested. 3. Review of the Program's policies and procedures revealed staff would document any unusual event with a tenant that occurred in the building or on the premises on an Incident Report form.	A 003		

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A 055	Continued From page 3	A 055		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide training regarding door alarms for 8 of 8 temp (temporary) agency staff who worked in April 2020 (Staff E, F, G, H, I, J, K and L). Findings follow: Record review on 7-21-20 of temp agency staff usage indicated eight temp staff worked at the Program in April of 2020. The Program had a Door Alarm Response policy that included the protocol for staff response to the door alarms. Training documents for temp agency staff related to door alarms could not be located. On 7-21-20 at 11:01 a.m. the Executive Director confirmed there were no training documents found for temp agency staff related to door alarms.	A 055		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and	A 089		

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A 089	Continued From page 4 preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans included all identified needs and preferences for assistance for 2 of 4 tenants reviewed (Tenants #2 and #4). Findings follow: 1. On 7-14-20 and 7-15-20 review of Tenant #2's face sheet in her file revealed she had an IPOST (Iowa Physician Order for Scope of Treatment), DNR (Do Not Resuscitate) order and was to receive comfort measures only. The tenant's service plan dated 10-11-19 reflected the IPOST, DNR status and comfort measures only, but did not provide information related to the comfort measures and the care to be provided related to those measures. 2. When interviewed on 7-21-20 at 8:13 a.m. the DON said Tenant #4 had displayed suicidal ideations to his family in June. Tenant #4's physician was contacted and a medication change occurred. He was placed on safety checks at night, his activity level was increased and one to one support was provided. Review of Tenant #4's record on 7-14-20 and 7-15-20 revealed a GDS score of four which indicated moderate cognitive decline. Progress Notes dated 6-12-20 indicated Tenant #4 expressed suicidal ideations to family. The service plan dated 7-3-20 included safety checks; however, did not reflect the suicidal ideations and other interventions in place.	A 089		

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A 089	Continued From page 5 3. On 7-21-20 at 8:13 a.m. the DON confirmed these findings.	A 089		

September 10, 2020

Deb Dixon, Program Coordinator
Adult/Special Services Bureau
Department of Inspections and Appeals
Health Facilities Division
Lucas State Office Building
321 East 12th St.
Des Moines, Iowa 50319-0083

10/29/20

Re: Summit Pointe Senior Living (ALP/D) Investigations 88817-C and #90650-C Plan of Correction

Dear Ms. Dixon,

Please find below the established plan of correction for the regulatory insufficiencies received on August 26, 2020.

A003 Insufficiency states "Program failed to ensure the policy regarding the completion of incident reports was not followed regarding 2 of 2 current tenants reviewed." Resulting in a substantiated Policy and Procedure complaint.

This insufficiency has been and will continue to be rectified by the following:

- Nurse consultant will educate the Director of Nursing and the Executive Director on incident report completion, timeliness, and necessary expectations. Completed 9/9/2020.
- Team education will be provided regarding incident report completion and timeliness. This will be completed on or before September 25, 2020.

Summit Pointe will ensure the problem does not reoccur by completing the following:

- Annual team member education on incident reporting.

Summit Pointe will monitor performance of the completion of incident report by:

- The Executive Director will complete twice monthly reviews of incident reports.
- Assisted Living Partners will review incident reports for regulatory compliance.

A055 Insufficiency states, 481-67.9(1) Staffing. "Program failed to provide training regarding door alarms for 8 of 8 temporary agency staff who worked in April 2020" This situation resulted in a substantiated staffing complaint.

This insufficiency will be rectified by the following:

- Implementation of an agency staffing orientation program.
- Summit Pointe will ensure agency staff will trained on identified criteria.
- Director of nursing will ensure training is complete before allowing them to work a schedule.

To ensure continued compliance Summit Pointe will verify training of agency staff with monthly billing.

This insufficiency will be rectified by no later than September 25, 2020.

10/29/20

A089 Insufficiency states, "Program failed to ensure service plans included all identified needs and preferences for assistance for 2 of 4 tenant reviewed." This insufficiency resulted in a substantiated Tenant Rights and Service Plan complaint.

This insufficiency will be rectified by the following:

- Director of Nursing will complete the ICAL AL Regulatory Course on or before September 15, 2020.
- Nurse consultant had provided education regarding Service Plans up to and including September 9, 2020.
- Team education regarding service plans will be provided on or prior to September 25, 2020.

Summit Pointe will ensure continued compliance by reviewing the completeness of the service plans with 90-day assessments and change of condition assessments.

Thank you for your time and attention. Please let me know if you have any questions.

Sincerely,

Cheri Orcutt
Executive Director