

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455678	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Summer Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Hollybrook Dr Longview, TX 75605	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 10 residents (Resident #1) reviewed for respiratory care . The facility failed to ensure that Resident #1 had a supply of oxygen in her portable oxygen tank. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Findings included: Record review of Resident #1's face sheet, dated 10/27/24 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included Displaced fracture of base of neck of left femur (a break in a bone that can be partial or complete), Cognitive impairment (problems with thinking, learning, memory, or judgment), Urinary tract infection (an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra). Record review of Resident #1's quarterly MDS assessment, dated 02/1/25, revealed Resident #1 had a BIMS of 14, which indicated she was cognitively intact. The MDS reflected that resident #1 required assistance with ADL's. The MDS reflected that Resident #1 was on oxygen therapy. Record review of an order for Resident #1 dated 10/27/24, revealed, O2 2-5l Via nasal cannula to Maintain Oxygen stats above 92%. During an interview and observation on 2/24/25 at 9:05 a.m. revealed Resident #1 was with a Family Member. She said that the oxygen tank attached to her wheelchair was empty of oxygen and the staff that just left said it was full. It was observed that ADON A was working with Resident #1's oxygen equipment while the surveyor was in the room. Upon observation of Resident #1's oxygen tank the needle on the dial was pointing to empty. Resident # 1 said the oxygen tank that was used when in the wheelchair was often times empty and she felt out of breath. During an interview on 2/24/25 at 9:34 a.m., with ADON A, she said she changed the tubing to Resident #1's oxygen but did not replace the empty oxygen tank. She said that Resident #1 was on continuous oxygen. (continued on next page)		

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 10:56 a.m. with the Director of Nurses she said that it was the responsibility of facility nurses to ensure that residents' oxygen tanks were full. She said that residents could be placed at risk of respiratory failure or altered mental status if not oxygenated properly. She stated that when an oxygen tank was empty it should be switched out to a full tank. During an interview on 2/26/25 at 11:00 a.m. with the Administrator, she said that it was the responsibility of nursing staff to ensure that residents' oxygen tanks are replaced when they no longer have oxygen. She said that residents could be placed at risk of distress if their oxygen levels got low. Record review of facility policy titled Oxygen Administration dated 9/2017 revealed that, The purpose of this procedure is to provide guidelines for safe oxygen administration Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration Review the resident's care plan to assess for any special needs of the resident.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 5 residents (Resident #2 and Resident #3) reviewed for infection control practices. 1. The facility failed to ensure the ADON applied enhanced barrier precautions when she assisted the nurse with positioning and holding Resident #2 during wound care treatment on 2/20/2025 at 1:24 PM. 2. The facility failed to ensure CNA B applied enhanced barrier precautions when she assisted the nurse with positioning and holding Resident #3 during wound care treatment on 2/26/2025 at 11:55 AM. 3. The facility failed to ensure Resident #3 was clean and dry after wound care was performed by CNA B and Treatment nurse on 2/26/2025 at 11:55 AM. These failures could place residents at risk of cross-contamination and infections leading to illness. Findings included: 1. Record review of Resident #2's Face sheet dated 2/24/2025 indicated the resident was a 90-year- old female who admitted to the facility on [DATE] with diagnoses of gastrostomy (a feeding tube inserted into the stomach through the abdomen) , volvulus (a condition where part of the intestine twists around itself and cuts off blood supply) pressure ulcer of left buttock, Stage II (a sore that has broken through the top layer of the skin and part of the layer below resulting in a shallow, open wound) , malignant neoplasm of colon (a type of cancer that develops in the tissues of the colon), cognitive communication deficit (a problem with one or more cognitive processes involved in communication such as attention, memory, and reasoning), and vascular dementia (a type of dementia caused by brain damage from impaired blood flow). Record review of Resident #2's MDS assessment, dated 1/3/2025, indicated the resident had a BIMS score of 7 which indicated the resident had severe cognitive impairment. The MDS also indicated Resident #2 required substantial/maximal assistance with bathing and dependent with dressing lower body. Record review of Resident #2's Care Plan created on 02/07/2025 indicated the resident had enhanced barrier precautions related to wounds. The care plan initiated on 2/10/2025 indicated Resident #2 had a Stage III pressure ulcer to the sacrum (a deep wound that extends through the skin into the fatty tissue of a triangular bone in the lower back formed from fused vertebra and situated between the two hipbones of the pelvis). During an observation on 2/20/2025 at 1:24 PM, revealed the ADON was observed assisting the Treatment Nurse with wound care for Resident #2 Stage III sacrum wound. The ADON was observed not wearing PPE (Personal Protective Equipment), a gown, while holding Resident #2 for her wound care treatment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #3's face sheet dated 2/26/2025 indicated the resident was a [AGE] year-old female resident who was readmitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a change in how brain works due to underlying condition), sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death), hypertension (when the pressure in your blood vessels are too high (greater than 140/90), neuralgia and neuritis (An inflammation of the peripheral nervous system which can cause pain, weakness, numbness, and changes in sensation), and stage IV pressure ulcer (a sore that extends into the muscle, tendon, ligament cartilage or bone). Record review of Resident #3's quarterly MDS assessment, dated 1/17/2025, indicated Resident #3 had a BIMS score of 12 which indicated resident had moderate cognitive impairment. The MDS also indicated Resident #3 was dependent with dressing, toileting, and bathing. Record review of Resident #3's Care Plan created on 02/06/2025 indicated that resident had Stage IV pressure ulcer to Sacrum requiring wound care as follows: Cleanse with normal saline, pat dry, apply collagen, calcium alginate and cover with a foam silicone dressing daily. The care plan interventions included Resident #3 would be kept clean, dry, and free of irritates and provide incontinence care after each episode. During an observation on 2/26/025 at 11:55 AM, revealed CNA B did not wear PPE while assisting the Treatment Nurse with wound care. CNA B stated Resident #3 was wet and was looking for a new brief. The Treatment Nurse looked for a new brief while CNA B continued to hold Resident #3 on her right side. CNA B and the Treatment Nurse could not locate a new brief and rolled Resident #2 on her soiled brief to retrieve a clean brief. During an interview on 2/26/2025 at 12:12 PM, the Treatment Nurse said the resident was currently lying on the new dressing on a soiled brief. The Treatment Nurse said she was not wet prior to care. The Treatment Nurse said she should have held Resident #3 while CNA B went to get a new brief. During an interview on 2/26/2025 at 1:30 PM, CNA B said she did not have to wear PPE while assisting Resident #3 while assisting the Treatment Nurse with positioning for care. CNA B said she could not recall what EBP stood for. CNA B said she had been in-serviced on enhanced barrier precautions. CNA B said PPE should be worn by the nurse providing the care or if a resident had Covid or something contagious. CNA B said Resident #3 was not on the wet part of the brief and was on the sheet. CNA B said she had tucked the soiled brief under the resident. During an interview on 2/26/2025 at 1:38 PM, the Treatment Nurse said she saw the CNA lay Resident # 3 back down on the soiled brief. The Treatment Nurse said she redressed the wound. The Treatment Nurse said the dressing or wound could get soiled, or the dressing could become dislodged and cause an infection. The Treatment Nurse said the dressing must be kept clean, dry, and intact. The Treatment Nurse said Enhanced Barrier Precautions were used to prevent infection. The Treatment nurse said Enhanced Barrier Precautions protected the staff and cross contamination to other residents. She said she had been in-serviced on EBP. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2025 at 1:44 PM, ADON A said any resident with an open wound, Foley , drains, tubing, IV or a weakened immune system were to be on EBP. She said PPE should be worn when direct care was provided. ADON A said PPE should be worn while in the room. ADON A said it protected the staff and resident. ADON A said she was supposed to wear PPE while assisting Resident #2 with wound care. She said the facility had plenty of PPE and was in-serviced on EBP. ADON A said not wearing proper PPE could cause infection if not worn properly and could cause infection to a resident or if a staff had dirtiness, it could be harmful. During an interview on 2/26/2025 at 1:50 PM, the DON said she expected the nurses to wear proper PPE while performing wound care. The DON said the facility had plenty of PPE and the staff had been in-serviced on EBP. The DON said if staff were not to wear proper PPE, it could cause cross contamination to staff, or the resident could get sick. The DON said everyone was responsible for ensuring the proper PPE was being worn. During an interview on 2/26/2025 at 2:06 PM, the ADM said the assisting staff should be wearing PPE if a resident had EBP. The ADM said EBP kept our germs to ourselves and their germs to their self. She said the resident could get sick, or the staff could get sick. The ADM said cross contamination could occur. She said she expected the staff to wear PPE and follow EBP precautions. The ADM said everyone was responsible for ensuring proper PPE was used. The ADM said the staff had been in-serviced. During an interview on 2/26/2025 at 2:44 PM, the ADM said she expected the staff to make sure the residents were clean and dry after wound care was performed, and a resident should not lay back in a soiled brief. The ADM said the CNA and Treatment Nurse were responsible at the time of care and the charge nurse, ADON, and DON were responsible for ensuring care was provided. During an interview on 2/26/2025 at 2:45 PM, the DON said she expected the residents to be clean and dry after wound care and the resident to have a clean brief on. She said it could result in infection if a resident was placed back in a soiled brief. She said she expected one staff to hold resident while a new brief was retrieved. The DON said the Treatment Nurse and CNA were responsible. Record review of an enhanced barrier precautions policy undated and titled Enhanced Barrier Precautions Policy revealed: Purpose: .policy aims to mitigate the risk of transmission of Multidrug-Resistant Organisms (MDROs) within Live Oak Healthcare facilities by implementing Enhanced Barrier Precautions. This policy seeks to prevent the spread of MDROs among residents and staff members by expanding the use of personal protective equipment (PPE) during high-contact resident care activities for certain residents. Background .Residents in skilled nursing facilities are particularly vulnerable to colonization and infection with MDROs .Definition .EBP are an infection control intervention designed to reduce transmission of MDROs in nursing homes. High-Contact resident care activities are activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Examples of high contact resident care activities .Dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting (including ostomy (surgery to create an opening (stoma) from an area inside the body to the outside) care), device care or use: central line, urinary catheter, feeding tube, tracheostomy (a surgical procedure that creates an opening in the neck to provide airway into the windpipe)/ventilator, wound care: any skin opening requiring a dressing. Training and implementation .Staff awareness and training .All staff members will receive initial training on EBP upon hire and refresher training annually thereafter (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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