

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 07/29/2025
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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
---	-------	-----------

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 07/29/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet residents highest practicable physical, mental, and psychosocial needs for 1 of 5 residents reviewed for care plans, (Resident #1). Resident #1 did not have a fall mat in place when he was found on the floor on 6/30/25. His care plan dated 5/9/25 indicated he was to have a fall mat. This failure could place residents at risk of not receiving the care required to meet their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of Resident #1's undated face sheet indicated he was a [AGE] year-old male that admitted [DATE] with diagnoses that included: Cerebral infarction (a stroke, death of brain tissue caused by a blockage of blood flow to the brain leading to lack of oxygen to the brain), mild cognitive impairment due to unknown etiology (subtle but measurable decline in memory and thinking), metabolic encephalopathy (a brain disorder caused by an underlying systemic illness affecting the body's metabolism characterized by changes in mental status, including confusion, memory problems, and altered behavior), and hemiplegia and hemiparesis affecting left dominant side (mild or partial weakness to complete paralysis of one side of the body). Record review of the significant change MDS dated [DATE] indicated Resident #1 had a BIMS score of 0, indicating severe cognitive impairment. The MDS indicated he had behavioral symptoms daily that was not directed toward others. He was totally dependent on staff for transfer. Record review of the care plan dated 5/9/25 indicated Resident #1 was a risk for falls and the interventions were: place bed in lowest position, fall mat, therapy screen, resident to be up in common areas. Record review of an Unwitnessed Fall Report dated 6/30/25 indicated Resident #1 was found lying in the floor at bedside on his left side. Fall mat was not at bedside. CNA (unknown) moved the fall mat while feeding lunch and did not return it afterwards. No visible injuries noted, but resident reported left knee pain. Fall mat placed at bedside. Bed left in lowest position. Neurological checks were initiated. MD, DON, ADM, and family notified. During an interview on 7/28/25 at 1:12 PM, LVN A said she assessed Resident #1 after he was found in the floor on 6/30/25. She said the bed was low, but the fall mat was not there. The bed was against one wall and the fall mat was propped up against the other wall. Someone had moved it and not put it back. She said she assessed him and saw no skin tears or injuries; however, he said his left knee hurt. He refused any medication for pain. She said when she left her shift that day (6/30/25) the X-ray technician was there to get the X-ray of Resident #1's knee. During an interview on 7/28/25 at 3:35 PM, LVN C said she saw Resident #1 on 6/30/25 and assisted LVN A to assess him after he was found in the floor. He had no skin tears or visible injuries. He said his left knee was hurting. She said she did not notice where the fall mat was, but it was not where Resident #1 was found or on the floor near him. She said the fall mat should have been by his bed because that was one of the preventions for an injury if he fell. She said she had no idea who moved the fall mat. During an interview on 7/29/25 at 8:58 AM, CNA D said sometimes she would move a resident's fall mat when she fed them, but it was important to move the fall mat back to prevent an injury to the resident if they fell. She said she knew the importance of a fall mat. She said the fall mat at bedside was part of the resident's care plan. During an interview on 7/29/25 at 9:03 AM, CNA B said a fall mat was placed at a resident's bedside to help to prevent an injury if they fell and it was important for resident safety. He said he always put a resident's fall mat back if he had moved it. During an interview on 7/29/25 at 9:48 AM, ADON E said Resident #1 was found in the floor on 6/30/25. He had a knee X-ray because he said his knee was hurting. His knee X-ray was negative for fracture. ADON E said his fall mat was not in place to the best of her knowledge on 6/30/25. She said the notes she read indicated the fall mat was not where it should have been. It was important that Resident #1's fall mat be there to keep fall preventions in place. She said a fall mat could cushion a fall and possibly prevent a fracture or injury. During an interview on 7/29/25 at 10:06 AM, RNC said Resident #1 was found in the floor 6/30/25. She said his fall mat was not on the floor near his bed, and he was not on the fall mat. She said a CNA had moved the fall mat, but she did not know who. She said fall mats can sometimes prevent a fracture. Fall mats are there as an extra precaution. She said Resident #1 was care planned for a fall mat, but staff [BH1] were not following their care plan. RNC said a risk of a fall mat not being where it should, was fracture and a risk of any other kind of injury. During an interview on 7/29/25 at 10:41 AM, the ADM said Resident #1 was found in the floor on 6/30/25 and was assessed by LVN A. She said his knee was hurting</p>		