STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455678	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summer Meadows	301 Hollybrook Dr Longview, TX 75605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 2 of 18 residents (Residents #30 and #65) reviewed for MDS assessment accuracy. 1. Resident #30's significant change MDS dated [DATE], identified the resident was receiving an anticoagulant. However, Resident #30 was not receiving an anticoagulant. 2. Resident #65's admission MDS, dated [DATE], identified the resident was receiving an anticoagulant. However, Resident #65 was not receiving an anticoagulant. These failures could place residents at risk of not receiving adequate care and services to meet their needs. Findings included: 1.Record review of the undated face sheet indicated Resident #30 was a [AGE] year-old female that admitted [DATE] and readmitted [DATE]. Record review of the physician's orders dated 5/6/25 indicated Resident #30 had diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting her right dominant side (weakness or paralysis on one side of the body following a stroke/brain injury), Type 2 Diabetes (the body has trouble controlling blood sugar), and hypertension (the force of blood against the artery walls is too high). The physician's orders did not indicate Resident #30 was ordered or taking an anticoagulant. Record review of the significant change MDS dated [DATE] indicated Resident #30 had unclear speech, understood others, and was usually understood by others. She had a BIMS score of 8, indicating moderate cognitive impairment. The MDS indicated she was taking an anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin). Record review of the care plan dated 4/16/25 indicated Resident #30 had a self-care deficit related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. The care plan indicated she was at risk for bruising and bleeding due to aspirin therapy. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of the undated face sheet indicated Resident #65 was a [AGE] year-old male that admitted [DATE]. Record review of the physician's orders dated 5/6/25 indicated Resident #65 had diagnoses that included: cerebral infarction due to embolism of right middle cerebral artery (a stroke caused by a blood clot that traveled through the bloodstream and blocked a blood vessel in the brain resulting in tissue death), Type 2 Diabetes (the body has trouble controlling blood sugar), and a coagulation deficit (the blood has difficulty clotting, leading to prolonged bleeding).). The physician's orders did not indicate Resident #30 was ordered or taking an anticoagulant. Record review of the admission MDS dated [DATE] indicated Resident #65 had clear speech, understood others, and was understood by others. The MDS indicated he had a BIMS score of 8, indicating moderate cognitive impairment. The MDS indicated he was taking an anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin). Record review of the care plan dated 4/21/25 indicated Resident #65 required the use of Aspirin 81 mg related to cerebral infarction/embolism of right middle cerebral artery. During an interview on 5/06/25 at 9:47 AM, the MDS nurse said she worked under the Regional MDS nurse. She said the only reason Resident #30 and Resident #65 were marked for an anticoagulant on their MDS was because they were both taking low dose aspirin. She said she was new and did not know if that was correct or not. During an interview on 5/06/25 at 9:52 AM, the Regional MDS nurse said Resident #30 and Resident #65 were marked for an anticoagulant on their MDS's because they were getting low dose, 81 mg aspirin. She said Resident #30 and Resident #65 should not have been marked for an anticoagulant. She said those MDS's were coded incorrectly. During an interview on 5/7/25 at 2:38 PM, the ADON said Resident #30 and Resident #65 should not have been marked for an anticoagulant. She said neither resident was on an anticoagulant. She said the risk of the MDS's being marked wrong was that the resident might not be assessed in the correct way and the nurse would not know what was correct regarding anticoagulant. She said the Regional MDS nurse was responsible for making sure the MDS's were coded correctly. The DON was not available for interview. During an interview on 5/7/25 at 2:49 PM, the ADM said MDS's should be accurate, and a resident should not be marked for an anticoagulant if they were not on that type of medication. She said the MDS determined the plan of care. She said the risk was claiming something that was not correct. She said the Regional MDS nurse, and the DON were responsible for the MDS being coded correctly. The ADM provided a Resident Assessment policy and said that was all she had regarding accurately coding MDS assessments. During an interview on 5/7/25 at 3:01 PM, the Regional DON said the MDS should be correct regarding anticoagulant medication. She said the DON and Regional MDS nurse were responsible for making sure the MDS's were correct. The ADM should review the MDS for accuracy. She said miscoding was no risk to a resident . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Resident Assessments Policy with a revised date of March 2022 indicated: Policy Statement A comprehensive assessment of every resident's needs is made at intervals designated by OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) requirements . .1.The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 2 of 19 residents reviewed for care plans. (Resident #34 and Resident #55) 1. The facility failed to resolve and update a care plan for Resident #34's removed PICC line (a long, thin, flexible tube inserted into a vein in the arm and threaded up to a large vein above the heart for easy access for administering intravenous medications, fluids, and nutrition) and incision care to right femur on 5/5/2025. 2. The facility failed to update a care plan for Resident #55's dietary orders from pureed to mechanical soft on 1/3/2025. These failures could place residents at risk of not having individual needs met and cause residents not to receive needed services. Findings included: 1. Record review of a face sheet printed 5/5/2025 indicated Resident #34 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including sepsis (a serious condition in which the body responds improperly to infection), diabetes (a group of diseases that result in too much sugar in the blood), hypertension (a condition in which the force of the blood against the artery walls is too high) and cerebral infarction (a condition where the brain tissues dies due to a lack of blood flow). Record review of an admission MDS assessment dated [DATE] indicated Resident #34 was usually understood and understood others. The MDS indicated Resident #34 had adequate hearing, clear speech, and adequate vision. The MDS indicated Resident #34 had a BIMS score of 12 which indicated moderate cognitive impairment. The MDS indicated Resident #34 required substantial assistance for toilet hygiene, shower/bathe self, dressing, and personal hygiene, and moderate assistance with oral hygiene. The MDS indicated Resident #34 was dependent for rolling left and right and sitting to lying, and moderate assistance for lying to sitting on side of bed. Record review of a care plan initiated on 3/31/2025 indicated Resident #34 indicated she had a PICC/Midline (a long, thin, flexible tube inserted into a vein in the arm and threaded up to a large vein above the heart for easy access for administering intravenous medications, fluids, and nutrition) to right upper extremity for short-term antibiotic therapy. The care plan included intervention to close clamp when not accessing the line or change infusion bags/tubing, dressing changes performed weekly basis or when dressing was soiled, wet or loose. Resident #34 had a care plan indicating a surgical wound to right hip and right femur (the bone located in the thigh) with interventions to apply appropriate wound dressings as ordered. The care plan indicated on 4/12/2025 Resident #34 had 6 sutures to right hip and 4 sutures to right femur and wound care to be performed to right hip and right femur as follows: paint with betadine and cover with a dry dressing daily. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of treatment administration record dated 5/1/2025-5/31/2025 indicated Resident #34's wound care to her right hip and right femur was discontinued to 5/5/2025. During an observation and interview on 5/5/2025 at 10:03 AM, Resident #34 said she had a wound to her bottom and was observed to be on a low air loss mattress. During an interview on 5/6/2025 at 9:23 AM, the Treatment Nurse said Resident #34 had a pressure ulcer when she admitted in March and agreed to observation of wound care provided today. During an observation on 5/6/2025 at 1:23 PM, Resident #34 was seen by the Treatment Nurse with CNA assisting with positioning for wound care to her pressure ulcer to her sacrum. Resident #34 was not observed to have a dressing or bandage to her right hip or right femur. During an interview on 5/7/2025 at 11:12 AM, LVN C said she did not perform wound care on residents unless the treatment nurse was not here. LVN C said she reviewed the care plans intermittently but mainly looked at the orders. She said the orders and the care plans should match. LVN C said she was aware Resident #34's incision to her right hip and right femur had dehisced (occurs when the edges of a surgical incision or wound separate, exposing underlying tissue) but was not sure if she still had the incision wound. LVN C said she changed her brief and Resident #34 did not have an open incision during her care. LVN C said it could be confusing if wound care was still on the care plan and not the orders. LVN C said the Treatment nurse was responsible for updating the wound care on the care plans. LVN C said it would not change the care provided to the resident. During an interview on 5/7/2025 at 11:26 AM, the Treatment Nurse said the MDS nurse was responsible for the care plans, but it was a team effort. The Treatment Nurse said she updated the care plan along with the DON. She felt that 3 days to a week was a reasonable time to update the care plans. The Treatment nurse said the care plans were a guideline on the care the residents receive. She said the care plan and the orders should match. She said if a care plan was not updated, it could impact a resident because the resident could receive the wrong diet or treatment. The Treatment Nurse said she notifies the MDS nurse and lets her know of changes and the DON and MDS nurse update the care plans. She said the care plan should be updated. The Treatment Nurse said she was not sure if the MDS Nurse was behind on care plans. The Treatment Nurse said if the care plan was not updated, it could cause confusion. The Treatment Nurse said Resident #34's care plan was not updated, and she verified Resident #34 no longer had a PICC line and was not receiving treatment to an incision line. 2. Record review of a face sheet printed on 5/7/2025 indicated Resident #55 was a [AGE] year-old, female and readmitted on [DATE] with diagnoses including aneurysm of the ascending aorta, without rupture (a bulge in the aorta, the body's main artery, specifically in the section that rises upwards from the heart), acute respiratory failure with hypercapnia (occurs when the body's ability to remove carbon dioxide (CO2) from the blood, dementia (a group of thinking and social symptoms that interferes with daily functioning), dysphagia (difficulty swallowing foods or liquids) and cerebral infarction (a condition where brain tissue dies due to a lack of blood flow). Record review of an order summary dated 5/7/2025 indicated Resident # 55 had an enteral feeding order for flushes every day and night shift with 60 cc of water each shift and for the head of bed to be at least 30 degrees during feeding and for 1 hour after feeding. The order summary did not indicate a specific diet order for Resident #55. Resident #55 had an order for the Dietician to evaluate and treat. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Dietician progress note dated 5/6/2025 indicated Resident #55 was on a regular, mechanically soft diet. Record review of a care plan dated 4/12/2025 indicated Resident #55 had impaired swallowing related to cerebral infarction with interventions for pureed diet and thin liquids and the need to monitor to advance diet consistency. There was not a specific care plan for diet. During an observation on 5/5/2025 at 9:28 AM, Resident #55 was sitting upright in the bed with water pitcher on bedside table. RP for Resident #55 said the food was good, but he had noticed she had not been eating over the last week. RP said she was not sure if Resident #55 was receiving protein shakes or vitamins. He said she had a feeding tube in the past for feedings but was currently taking food by mouth. During an interview and observation on 5/7/2025 at 10:42 AM , LVN B said Resident #55 ate this morning scrambled eggs and finely grounded sausage. LVN B said she assisted Resident #55 this morning with eating and stated she ate half her eggs. LVN B said she did not consider the meal consistency to be pureed but mechanical soft. LVN B said Resident #55 was upgraded to mechanical soft. LVN B said the orders indicated Resident #55 was on mechanical soft with thin liquids. During an observation on 5/7/2025 at 1:31 PM, Resident #55 was lying on bed with eyes closed and lunch tray at bedside. The RP said Resident #55 was waking up to eat. Resident #55's meal sheet indicated she was on a mechanical soft diet. Resident #55 was assessed by LVN B and transferred to the hospital due to coughing and not opening her eyes. During an interview on 5/7/2025 at 1:35 PM , LVN B provided a copy of a communication form dated 1/3/2025 from Speech Therapist indicating Resident #55's diet was advanced on 1/3/2025 for mechanical soft diet and thin liquids. During an interview on 5/7/2025 at 2:56 PM, the MDS nurse said she was responsible for entering the care plans in the system, but it was a team effort. The MDS nurse said the care plan orders for Resident #55 should match the diet on the orders. The MDS Nurse said it could be a discrepancy. The MDS Nurse said the diet not on the care plan could negatively impact Resident #55 because she could receive the wrong diet or treatment. During an interview on 5/7/2025 at 3:42 PM, the ADON said Resident #55 the MDS nurse was responsible for care plans and every new order. She said the MDS Nurse would receive new orders and add to the care plan after the care meeting in the mornings. The ADON said the DON, ADON and Treatment Nurse had also been assisting with updating the care plans. The ADON said the care plans were important so the nurses would know how to provide care and the nurses were to review the care plans daily. The ADON said if a problem area were resolved, the care plan would indicate resolved. The ADON said the nursing staff could miss providing care on a problem area or provide wrong care if not resolved which she said could harm the resident. The ADON said the PICC line on Resident #34 should have been resolved and the diet on Resident #55's care plan had been updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 3:54 PM, the Regional Nurse said the staff should be using the new EMR (electronic medical record) and the care plans should be updated from the old EMR (electronic medical record) program. The Regional Nurse said the Regional MDS Nurse was responsible for ensuring the care plans were updated. The Regional Nurse said the MDS Nurse currently at the facility was new and still learning. The Regional Nurse said the DON should be updating the care plan on any acute concerns, infections or falls. The Regional Nurse said the care plans were used to provide individualized quality of care for each resident. She said she expected the orders and care plan to match the care provided. The Regional Nurse said if the care plans were not updated, it could cause a resident to have a poor outcome if not followed or care was implemented incorrectly. She said care could be missed or provided incorrectly. During an interview on 5/7/2025 at 4:01 PM, the ADM said the EMR was in effect as of 4/11/2025 and she expected the staff to be using the new EMR for care plans. The ADM said the MDS nurse was responsible for the care plans. The ADM said the care plans were a guide to the resident's care and were a snapshot of the resident's behaviors, diets, etc. The ADM said she expected the care plans and orders to match. The ADM said it was important to update the care plans because if a resident were ordered a special diet consistency, the resident could aspirate or have dignity issues if the meal was pureed . Record review of a facility Care Plans, Comprehensive Person-Centered policy revised March 2022 indicated .a comprehensive, person-centered care plan .meet the resident's physical, psychosocial and functional needs is developed and implemented .the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive .includes measurable objectives and timeframes . reflects currently recognized standards of practice for problem areas and conditions .assessments of residents are ongoing and care plans revised as information about the residents and residents' condition change . the IDT must review and update the care plan .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review the facility failed to ensure each resident's environment remained free of accident hazards for 1 of 22 residents (Resident #33) reviewed for accident hazards. The facility failed to keep prohibited items, hydrogen peroxide topical solution, out of Resident #33's room. This failure could place residents at risk for injury, harm, and impairment or death. Findings included: Record review of Resident #33's Face Sheet indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Heart Failure (a condition where the heart cannot pump enough blood to meet the body's needs), Urinary Tract Infection (an infection in any part of the urinary system, including the kidneys, bladder, urethra, or ureters), Pneumonia (a lung infection that inflames the air sacs and can fill them with fluid or pus). Record review of Resident #33's MDS dated [DATE] revealed that the resident's BIMS score was a 13 indicating no cognitive impairment. The MDS also revealed, Resident #33, required minimal assistance for all ADLs . During an observation and interview on 5/5/25 at 10:18 a.m., Resident #33 had a bottle of hydrogen peroxide topical solution in her room. She said that she did not know where the item came from and did not know if she should have it or not. There were many general hygiene items in the bathroom with the hydrogen peroxide topical solution but were mostly perfumes and lotions. During an interview on 5/5/25 at 10:28 a.m., LVN A said that Resident #33 can self-transfer and ambulate with her wheelchair. She said that residents should not have hydrogen peroxide topical solution in their rooms as it could be dangerous if Resident #33 used it improperly or another resident entered her room and drank it. During an interview on 5/7/25 at 3:38 p.m., the Assistant Director of Nurses L said that residents were not allowed to keep hydrogen peroxide topical solution in their rooms as it could be dangerous if used in the wrong way. She said that all staff should remove prohibited items from resident's rooms. During an interview on 5/7/25 at 3:09 p.m., the Administrator said that all staff are responsible for removing prohibited items from resident's rooms. She said that hydrogen peroxide topical solution is a prohibited items and it could harm a resident if it wasn't used properly. Requested a policy on 5/7/25 at 1:00 p.m. regarding accidents, hazards, and prohibited items in resident's rooms. Administrator was unable to produce a policy regarding this concern.

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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 22 residents (Resident #4) reviewed for respiratory care. 1. The facility failed to change the oxygen tubing for Resident #4. 2. The facility failed to ensure that Resident #4's oxygen concentrator reservoir was filled with water. 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 #4's face sheet, dated 3/16/24 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included Chronic Obtrusive Pulmonary Disease (a progressive lung disease that makes it hard to breathe), Pneumonia (a lung infection that inflames the air sacs and can fill them with fluid or pus), Hypokalemia (a condition where the amount of potassium in the blood is lower than normal). Record review of Resident #4's quarterly MDS assessment, dated 04/18/25, revealed Resident #4 had a BIMS of 04, which indicated she had severe cognitive decline. Shows that resident #4 requires oxygen therapy. Record review of an order for Resident #4, dated 1/24/24, shows that staff were to provide, Oxygen continuously via Nasal Cannula. May titrate between 2-5 liters per minute for shortness of breath or pulse oximetry < 90% every day and night shift for shortness of breath and to maintain pulse ox > 90%. Record review of Resident #4's care plan revealed a problem initiated on 4/21/25, Resident #3 requires oxygen therapy due to COPD (Chronic Obtrusive Pulmonary Disease) and CHF (Congestive Heart Failure.) During an interview and observation on 5/5/25 at 9:09 a.m. Resident #4's oxygen concentrator was dated 4/28/25 and the oxygen concentrator water reservoir was empty. Resident #4 was asked if she had any issued with her oxygen concentrator but was unable to answer the question. During an observation 5/6/25 at 8:18 a.m. Resident #4's oxygen concentrator tubing was dated 4/28/25 and there was no water in the oxygen concentrator water reservoir. During an observation 5/7/25 at 8:33 a.m. Resident #4's oxygen concentrator tubing was dated 4/28/25 and there was no water in the oxygen concentrator water reservoir. Resident was laying in bed using the oxygen concentrator . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 3:38 p.m., the Assistant Director of Nurses L said the night nurses are responsible to ensure that residents with oxygen concentrators have their tubing changed on schedule and their water reservoirs filled. She said that there was a risk that residents could have a respiratory infection and that their nasal passage could be dried out . During an interview on 5/7/25 at 3:07 p.m., the Administrator said nursing staff was responsible to ensure that oxygen tubing was changed per policy and schedule. She said that the tubing could break down and the residents could be more susceptible to respiratory infections. She said that the water reservoir should also be kept filled. Record review of facility policy titled Oxygen Administration revised in October of 2010 revealed that, The purpose of this procedure is to provide guidelines for safe oxygen administration Oxygen/nebulizer tubing/masks to be changed by nursing department, weekly, and documented in the electronic health record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35295 Based on observation and record reviews, and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. 1.The facility failed to ensure the handwashing sink had been cleaned. 2.The facility failed to ensure the floor of the kitchen had been cleaned. These failures could place residents at risk of foodborne illness and food contamination. Findings included: During an observation on 5/5/25 at 8:30 AM, an initial tour of the kitchen was conducted. The following was observed: 1)The handwashing sink had a brown substance on the sides of the sink and in the bowl. 2) The floor was sticky and had debris, (wrappers and crumbs) in numerous locations of the kitchen. During an interview on 5/5/25 at 8:30 AM, DA E said the handwashing sink was dirty and should have been cleaned by the last shift but apparently it was not. [NAME] D said the kitchen was not clean when she got to work this morning at 5:00 AM, and the night shift should have cleaned it. During an observation and interview on 5/5/25 at 8:34 AM, this surveyor's shoes were sticking to the floor in front of the milk box. DA E said the floor was really sticky and her shoes were sticking to the floor. She said The floor should not be this sticky. During an interview on 5/5/25 at 8:36 AM, DA E said there were food crumbs in numerous areas of the kitchen on the floor. She said she would sweep and mop because the prior shift obviously had not done it and the floor was dirty and sticky. [NAME] D said she had to clean the steam table before she started cooking and had not had time to clean the handwashing sink yet. During an interview on 5/05/25 at 3:07 PM, the ADM said she went into the kitchen this morning about 8:45 AM and it was dirty. She said her feet were sticking to the floor and the sink was dirty when she went to wash her hands. She said there were no paper towels to dry her hands and the kitchen staff had to get some for her. She said it was everyone's job in the kitchen to keep it clean. She said it was an infection control issue because the kitchen was not sanitary. She said she told the staff to clean all areas of the kitchen before preparing lunch. She said she did not know how dirty the kitchen was when staff prepared breakfast. She said the DM was out and would not be available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455678	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summer Meadows	301 Hollybrook Dr Longview, TX 75605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 5/06/25 at 11:03 AM, [NAME] F said she worked Sunday (5/4/25) and left about 2:00 PM. She said the kitchen was clean when she left. She said she cleaned all day as she went and always mopped the floors. She said the kitchen should always be clean when you leave your shift. During a telephone interview on 5/06/25 at 11:05 AM, DA J said she worked Saturday (5/3/25), was in training that day and left at 2:30 PM. She said she did not do any cleaning but someone was mopping and she did not know her name. She said she did not work on Sunday (5/4/25). During an interview on 5/06/25 at 11:56 AM, the dietician said she expected the floors to be swept and mopped, clean, and not sticky. She said she expected the handwashing sink to be clean. Overall, the kitchen should be clean. She said if the kitchen was not clean it could be an infection control issue and could cause poor outcomes for residents. She said if the cleaning schedule was being falsely reported she did not know what else was not being cleaned so it could be a cross-contamination issue for residents. During a telephone interview on 5/06/25 at 5:16 PM, DA G said she worked Sunday (5/4/25) morning and got off just after 2:00 PM. She said the kitchen was not dirty when she left. She said the floor was not sticky and the sink was not dirty. She said there was a bag of juice that busted in front of the milk box and that was sticky, but DA H cleaned it up. She said she did not know if it was still sticky when she left because she did not go out that way. She said the cook, [NAME] F usually cleaned the floor. She said [NAME] F was constantly cleaning and washing her hands. She said she was not responsible for the entire kitchen floor. She said the cook was responsible for mopping the floor where the cooking took place. She said she did not really understand the cleaning schedule, she just cleaned what she knew she was supposed to clean. She said the kitchen should always be clean. On 5/6/25 at 5:33 PM, attempted a telephone interview with DA K. Her phone was not working. During a telephone interview on 5/07/25 at 10:29 AM, DA H said the kitchen absolutely was clean when she left Sunday (5/4/25) about 9:00 PM. She said a bag of juice had spilled by the milk box and she had mopped it more than 2 times. She said she mopped it normally, then with hot water, then mopped it again. She said she had mopped all the floors, and they were clean when she left. She said the handwashing sink was clean when she left. She said they would initial on the schedule what they had cleaned when they left for the shift. She said the kitchen must be clean when they leave for the day. She said if the kitchen was not clean it could be an infection control issue for the residents. During an interview on 5/7/25 at 2:38 PM, the ADON said she expected all areas of the kitchen to be clean before and after meal preparation. She said the floors should not be sticky, the sinks and cooking areas should be clean. She said the risk to residents was infection control which could cause food born illness. During an interview on 5/7/25 at 2:49 PM, the ADM said the kitchen should always be clean before and after meal preparation to prevent an infection control issue/food born illnesses. She said if the floors were sticky, it could be a slipping hazard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/7/25 at 3:01 PM, the Regional DON said the kitchen should be clean before and after cooking. She said infection control and sanitation was important for resident's health. She said a dirty kitchen caused a risk of cross contamination. She said the DM was responsible for the kitchen being clean and should be overseen by the ADM. Record review of the Daily Cleaning Schedule dated 5/4/25 indicated all areas of the kitchen had been cleaned. Sweeping and mopping of the kitchen floor, and sinks, faucets and handwashing sinks had been initialed by DA K and DA H. A Sanitization Policy with a revised date of November 2022 indicated: Policy Statement The food service area is maintained in a clean and sanitary manner. Policy Interpretation and Implementation 1.All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. 2.All untensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. 3. all equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions