STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Square	501 Oak Avenue Waynesboro, VA 22980

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare, and serve food in a sanitary manner in the main kitchen and on the on-unit kitchen on the one nursing unit having the potential to affect many residents on the one healthcare unit. The findings included:12/1/25 at 6:02 pm, an observation was conducted of the galley kitchen, located on the healthcare unit. Upon entering the galley kitchen, it was observed that on the beverage table there were 3 partial loaves of bread, open without any date as to when it was opened or to be used by. In the reach-in freezer there was a large container of ice cream that was open to air and had no indication of when it had been opened or was to be used by. There was a smaller metal container with multiple cream-colored cubes in it, wrapped in saran wrap and had no label to indicate the contents, date prepared, or date to be used. The server/cook (Other employee #1- OE #1) stated that it was butter. OE #1 said everything needs to be labeled to make sure everything is safe and in date for our residents and we aren't leaving it too long. In the reach-in cooler, the following items were observed that had no label or date of when prepared or to be used by: Three plates of tossed/garden salads, a serving pan of fresh fruit, sliced cheese, fruit cocktail in syrup, and a pan with a white creamy appearance that OE #1 identified as ranch dressing. OE #1 reported, It would have been brought down an hour or two ago, when asked how she knew when it was prepared or to be used by. On 12/1/25 at 6:21pm, the dietary manager (Other employee #2- OE #2) arrived in the galley kitchen. The above observations were shared with OE #2 and she confirmed all items should be labeled and dated to ensure they are used within the appropriate time frames. On 12/1/25 at 6:34 pm, observations were conducted in the main kitchen with the dietary manager-OE #2. In the dry storage room the following was observed: dry spaghetti noodles wrapped in clear plastic wrap, macaroni and ziti noodles that the bag top was just twisted and not secured, none of which had an open date or use by date. There was an open container of panko breadcrumbs that were labeled and indicated a use by date of 11/30/25. OE #2 stated that they no longer use the panko breadcrumbs because their menu had changed but acknowledged they were available for use. There was a zip lock bag of wonton strips that had a date of 9/17. When asked the dietary manager was unable to confirm if that was an open date or use by date. She retrieved a wonton strip from the bag with her bare hand and proceeded to eat it and said, its still good. Also in the dry storage room was a bulk flour container that had a bowl used to scoop out portions stored in the flour and there was no date on the bulk flour or sugar bins in the dry storage room. There was larger bulk bins of flour and sugar outside of the dry storage room that had contents in them without any date. The dietary manager reported they no longer used the flour or sugar in the larger bins in the main kitchen because they changed vendors but had not discarded the contents yet. On 12/1/25 observations of the walk-in freezer revealed a Ziplock bag that was not labeled. The contents were identified as tilapia fish filets by the dietary manager. There was no date when they were opened or to be used. According to the facility policy titled, Food Storage, with a revision date of 12/2025, it read, . 3. Plastic containers with tight-fitting covers must be used for storing bulk rice, flour, sugar, and breads. These containers must be legibly and accurately laveled. See attached label and stocking guidelines. 4. Scoops are not to be stored in the food containers. 10 . All breads and buns (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Square	501 Oak Avenue Waynesboro, VA 22980

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	need to be labeled and dated upon delivery or removal from the freezer. All breads and buns can be held up to 7 days. Discard after the 7th day. 11. Store leftovers covered in refrigerators in proper containers to meet time temperature controls. Each item should be dated and labeled (if not easily identified). Leftover food is used within 72 hours or discarded. All leftovers containing milk and egg products that are potentially hazardous are discarded after 48 hours. Open dates must be placed on yogurt, sour cream, sliced cheese, milk and cottage cheese and must be discarded after 7 days. 13 d. Rewrap packages of frozen foods that have been opened. f. To freeze leftover food, package in small units for quick freezing. Wrap product so it is airtight, label and date it. The policy went on to read on page 3, Guidelines for Labeling/Stocking. All items must have a label that includes: name of item, stock date, open date, and use by date. On the morning of 12/2/25, the facility administrator was made aware of the above findings.No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Square	501 Oak Avenue Waynesboro, VA 22980

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of fourteen residents in the survey sample (Resident #2).The findings include:Resident #2 was admitted to the facility with diagnoses that included diabetes, congestive heart failure, insomnia, neuropathy, osteoarthritis, asthma, anemia and chronic kidney disease. The minimum data set (MDS) dated [DATE] assessed Resident #2 as cognitively intact.On 12/2/25 at 4:38 p.m., Resident #2 was interviewed about any sleeping problems. Resident #2 stated sound sleep at times was an issue. Resident #2 stated interventions provided to assist with sleep included leg elevation in the evening, cool wraps to legs and the medication Trazadone. Resident #2 stated these interventions had been helpful with improving sleep problems.Resident #2's clinical record included a physician's order dated 11/21/25 for the medication Trazadone 125 milligrams (mg) with instructions to administer at each bedtime for treatment of insomnia. The resident's medication administration record documented this medication was administered each evening at 8:00 p.m. as ordered. Resident #2's plan of care (revised 11/13/25) included no problems, goals and/or interventions regarding insomnia. On 12/3/25 at 8:40 a.m., the registered nurse (RN #1) responsible for care plan development was interviewed about Resident #2's plan regarding insomnia. RN #2 reviewed Resident #2's care plan and stated the sleep medication was listed but nothing had been included in the plan about insomnia. RN #1 stated problems, goals and interventions for insomnia should have been included in the resident's plan of care.This finding was reviewed with the director of nursing on 12/3/25 at 8:50 a.m. with no further information provided prior to the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Square	501 Oak Avenue Waynesboro, VA 22980

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, facility document review and clinical record review, the facility failed to label a medication according to the physician's order for one of five residents in the medication pass observation (Resident #19).The findings include:A medication pass observation was conducted on 12/1/25 at 7:15 p.m. with licensed practical nurse (LPN #1) administering medications to Resident #19. Included in medications administered was escitalopram 15 milligrams (mg). The 15 mg escitalopram dose included two tablets. One tablet was from a pharmacy supply card labeled escitalopram 10 mg with instructions to give one tablet at bedtime for anxiety. The second tablet was from a pharmacy card labeled escitalopram 5 mg with instructions to give one tablet at bedtime for anxiety. Review of Resident #19's clinical record revealed a physician's order dated 11/24/25 for escitalopram 10 mg with instructions to give 1.5 tablets at each bedtime for anxiety.On 12/2/25 at 10:43 a.m., LPN #2 caring for Resident #19, was interviewed about the discrepancy between the escitalopram physician's order and the pharmacy labels. LPN #2 reviewed the medication supply cards in the cart and stated the pharmacy provided a card for a 10 mg dose and a card with a 5 mg tablet to equal the 15 mg ordered. LPN #2 stated the pharmacy label did not match the order in the electronic health record to give 1.5 tablets of 10 mg tablets. LPN #2 stated sometimes the pharmacy changed how the dose was supplied but that the pharmacy usually notified nursing so that the order could be amended. On 12/2/25 at 11:03 a.m., the director of nursing (DON) was interviewed about Resident #19's escitalopram pharmacy card labels not matching the order in the electronic health record. The DON stated the pharmacy label was supposed to match the physician's order. The DON stated the pharmacy at times changed how the dose was supplied based on available stock, but that pharmacy was supposed to advise nursing so that the order could be changed. The DON stated, Absolutely, the label should match the order. The DON stated that nurses had not notified her that the escitalopram pharmacy label did not match the physician's order in the electronic health record.On 12/2/25 at 1:40 p.m., the DON stated she contacted the pharmacy about Resident #19's escitalopram label/order mismatch. The DON stated the pharmacy responded that notification should be sent to the facility when any changes were made resulting in the label not matching the entered order. The DON stated the pharmacy reported they did not notify the facility regarding Resident #19's label modification of the escitalopram and that was why the label did not match the physician's order.The facility's policy titled Medication Management (revised 12/25) documented, It is the policy of the facility to maintain a safe and competent medication management system that is based on best practice and the care process of the residents that includes: recognition of the problem/need, assessment, diagnosis(es), medication administration, management, monitoring and revising the individualized, person-centered approach to care as well as documentation consistent with standards of medication management and administration standards .Prior to administration the medication and dosage schedule on the MAR [medication administration record] is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for correct dosage schedule .Medications are administered in accordance with written orders of the attending physician or physician extender .This finding was reviewed with the administrator and DON during a meeting on 12/2/25 at 4:50 p.m. with no further information presented prior to the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Square	501 Oak Avenue Waynesboro, VA 22980

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for one resident (Resident #1-R1) in a survey sample of fourteen residents. The findings included:For R1, the facility staff failed to maintain a complete clinical record to include hospital discharge records and visits with an outside provider, the urologist. On 12/2/25, review of the facility submitted Resident Matrix R1 was noted to be on an antibiotic. R1 was then selected for review of the facility's antibiotic stewardship program. On 12/2/25 at 9:40 am, during an interview with the facility's infection preventionist, who was registered nurse #1 (RN#1) and the director of nursing (DON), R1 and his antibiotic use was discussed. Both RN #1 and the DON reported that R1 had been hospitalized and diagnosed with an urinary tract infection and was admitted to the facility's healthcare unit following discharge from the hospital. They went on to report that R1 had been seen by the urologist on several occasions and changes to the antibiotic had been made by the urologist. On 12/2/25, during the above interview with RN #1 and the DON, resident #1's clinical record was accessed. The surveyor was unable to locate the hospital discharge records or progress notes from the urologist visits that resident #1 had. The DON also reviewed R1's clinical record and was unable to find the records. The DON said she would talk to medical records and see if they had the records and said, I have a QAPI (quality assurance/performance improvement) plan on it as well. We have been working on that. According to R1's census tab of the clinical record, they were admitted to the facility on [DATE]. According to the physician orders, R1 had urology appointments on 9/10/25, 9/19/25, 9/22/25, and 10/13/25. On 12/2/25 at 10:45 am, the facility administrator provided the survey team with copies of the urology visits progress notes and stated, the scheduler had the records downstairs [in the basement]. The administrator said, we're working on that [getting records uploaded into resident's clinical records], we expect it to be much faster than that. On 12/2/25, the director of nursing provided the surveyor with a document titled, QAPI Performance Improvement Plan. The document indicated the focus area was Timely Scanning of Medical Records and had a start date of 9/15/25. The facility had self-identified, Internal audits revealed inconsistent and delayed scanning of medical records (orders, notes, consult reports). Untimely uploads create incomplete charts and risk non-compliance with state survey standards for accurate and accessible documentation. The goal was to have records uploaded into resident's clinical records within 24-48 hours of receipt with a completion date of 1/30/26. While the facility had self-identified this deficient practice and developed a plan to correct the identified deficiency, corrections had not been performed at the time of survey, therefore past non-compliance was not achieved. On 12/2/25 at 12 noon, the facility administrator was made are of the above findings. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Square	501 Oak Avenue Waynesboro, VA 22980

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview and facility document review, the facility staff failed to perform hand hygiene between residents during a medication pass observation on one of one unit.The findings include:On 12/1/25 starting at 7:00 p.m., a medication pass observation was conducted with licensed practical nurse (LPN #1) administering medications to three residents. On 12/1/25 at 7:00 p.m., without prior hand hygiene, LPN #1 prepared and administered oral medications to Resident #9. LPN #1 touched and disposed of Resident #9's medication cup prior to exiting the room. Without performing hand hygiene, LPN #1 then prepared and administered oral medications to Resident #4. While administering medications to Resident #4, LPN #1 handled the resident's personal thermal mug in addition to the used medication cup. Without performing hand hygiene, LPN #1 then prepared and administered oral medications to Resident #19. On 12/1/25 at 7:21 p.m., LPN #1 was interviewed about the lack of hand hygiene between contact with multiple residents during the medication pass. LPN #1 stated, I should have done it [hand hygiene]. I guess I was distracted. LPN #1 stated she was aware that hand hygiene was supposed to be done between residents when giving medications.On 12/2/25 at 11:03 a.m., the director of nursing (DON) was interviewed about LPN #1 not performing hand hygiene between residents during medication administration. The DON stated nurses were expected to perform hand hygiene between residents when administering medications.The facility's policy titled Medication Management (revised 12/2025) documented, .Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications .The facility's policy titled Hand Hygiene (revised 04/2025) documented, .Hand Hygiene is an essential part of preventing transmission of organisms by healthcare workers by reducing the organisms on hands prior, during and after rendering care to residents .Hand hygiene refers to hand sanitizing either by soap and water hand-washing, antiseptic soap and water hand-washing or antiseptic hand rub .Indications for Hand hygiene .Before direct contact with a resident .This finding was reviewed with the administrator and DON during a meeting on 12/2/25 at 4:50 p.m. with no further information provided prior to the end of the survey.