STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observations, interviews, and record reviews, the facility failed to treat residents with respect and dignity and care for them in a manner and in an environment that promoted maintenance or enhancement of their quality of life for 1 of 8 residents (Resident #34) reviewed for resident rights. The facility failed to ensure CNA A provided privacy to Resident #34 when providing incontinent care on 3/04/2025. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increased anxiety. Findings include: Record review of Resident #34's facility face sheet dated 3/04/2025 revealed Resident #34 was an [AGE] year-old male and was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (lung disease causing shortness of breath). Record review of Resident #34's admission MDS assessment dated [DATE] revealed Resident #34 had a BIMS score of 5 indicating severely impaired cognition and required assistance with all activities of daily living. Record review of Resident #34's comprehensive care plan dated 02/12/2025 revealed Resident #34 had impaired self-care and required assistance with activities of daily living. During an observation 03/04/25 at 9:50 AM, CNA A was providing Resident # 34 with incontinent and catheter care. CNA A did not pull the privacy curtain and the hospice nurse opened the resident's door and entered the room, exposing Resident #34 to the hallway . During an interview on 03/04/25 at 10:02 am, Resident #34 said he was not aware someone walked in while the CNA was performing catheter care, but it was a little embarrassing to think someone that did not need to see him naked could. (continued on next page)

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
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 10:04 am, the hospice nurse said she knocked and entered the room without waiting for permission and when she opened the door, she should have closed it and not continued to open the door exposing the resident to the hallway. She said by not doing so it could cause the resident embarrassment. During an interview on 03/04/25 at 10:07 am, CNA A said when providing personal care to residents, she should always pull the privacy curtains. She said she pulled the middle curtain but forgot about the one at the door. She said by not pulling the curtain when the hospice nurse walked in the room, Resident #34 was exposed to the hallway. She said this could make the resident feel bad and embarrassed. During an interview on 03/05/25 at 8:50 am, the DON said all staff were responsible for ensuring residents' rights and dignity. She said staff were trained on hire, annually, and as needed on resident rights and dignity and training including the use of privacy curtains. She said she expected all staff to maintain the residents privacy and dignity to prevent embarrassment. She said she would see that all staff were retrained on privacy and dignity. During an interview on 03/05/25 at 9:16 am, the Administrator said she was responsible for resident rights in the facility and that staff were following the rules for resident rights. She said she expected when care was provided, the privacy curtains to be used to prevent resident exposure and possible humiliation. She said she would see that all staff were retrained on dignity and privacy during care. Record review of a Residents' Rights document dated November 2021 revealed, dignity and respect: you have the right to be treated with dignity, courtesy, consideration and respect .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on interview and record review, the facility failed to ensure the drug regimen review recommendation from the pharmacy consultant were acted upon for 2 of 4 residents reviewed for drug regimen review. (Residents #23 and Resident #253) -The facility did not follow up on the pharmacy consultant's recommendations dated 11/08/24 with the physician for Residents #23 and #253. -The facility did not develop policies and procedures to address the timelines of the MRR. These failures could place residents being at risk for medication errors, unnecessary medications, and incorrect administration. Findings included: 1. Review of Resident #23's admission face sheet dated 3/05/25 indicated Resident #23 was [AGE] year-old male, admitted on [DATE] with diagnoses including nontraumatic intercranial hemorrhage (bleeding within the skull), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (Fear characterized by behavioral disturbances). Review of the most recent MDS assessment dated [DATE] indicated Resident #23 was moderately cognitively impaired. During a record review of the monthly pharmacy consultant medication regimen review and recommendation dated 11/13/24, the review indicated: A recommendation as follows The resident has been taking Zoloft 50 mg daily and Celexa 10 mg daily (two SSRI's). Please evaluate the current dose and consider a dose reduction. During a record review of Resident #23 physician's orders dated December 2024 indicated that the order for Zolfoft 50 mg and Celexa 10 mg daily were not changed following the pharmacy recommendation dated 11/08/24. 2. Review of Resident #253's admission face sheet dated 3/05/25 indicated Resident #253 was an [AGE] year-old male, admitted on [DATE] with diagnoses including malignant neoplasm of the liver (liver cancer), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (Fear characterized by behavioral disturbances). Review of the most recent MDS dated [DATE] indicated Resident #253 was cognitively intact. During a record review of the monthly pharmacy consultant medication regimen review and recommendation dated 11/13/24, the review indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A recommendation as follows This resident had a recent fall. After reviewing the current medications, please evaluate the following meds for possible discontinuation or change as it has a high potential for causing or contributing to falls and possible fractures: Buspirone and Mirtazapine . During a record review of Resident #253 physician's orders dated December 2024, it indicated that no changes were made to the order for Buspirone and Mirtazapine following the pharmacy recommendations dated 11/08/24. During record review, no evidence of a physician's response to the medication regimen review for Resident # 23 or Resident # 253 was in the pharmacy consultant binder or the EMR. In an interview with the DON on 3/4/25 at 1:30 PM, she stated she was responsible for printing off the pharmacy consultant reports every month and sending all recommendations to the physicians for review and response. The DON said she has been responsible for the pharmacy reviews since January 2025. She said the previous ADON was responsible for the pharmacy consultant reports during the time in question. She stated the pharmacy consultant emails her the monthly report at the end of his visit. She prints out the reports and sends all recommendations to the physician within 24 hours of the visit. She stated she has been tracking the physician responses and follows up with any recommendations that have not been addressed. She stated she follows up on recommendations not returned by the physician weekly. She said when the recommendations are returned to the facility after the physician reviews and signs, the record is to be scanned and placed in the residents' EMR. In an interview with the Administrator on 3/5/25 at 10:45 AM, she said the DON wasresponsible for the pharmacy recommendations and medication review. She said the DON is responsible to sending the recommendations to the physicians and following up on any reports not returned. She said the DON has been overseeing the pharmacy recommendations since January 2025, and before that date, the ADON, that is no longer with the facility, was over the pharmacy recommendations. She said that she expects the recommendations to physician to be sent in a timely manner. She expects the response from the physician to be less than 30 days. In an interview with the pharmacy consultant on 3/5/2025 at 4:20 PM, he stated that he visited the facility on site monthly to perform medication reviews on all residents in the facility. He stated that during his visits, he reviewed the pharmacy binder for all communications relating to the previous pharmacy recommendations. He said if a recommendation from the previous month has not had a physician's response, he will make a notation on the report that the response is pending. He stated it is the facilities responsibility to follow up with the resident's physician to obtain a response to the pharmacy recommendations in a timely manner. He stated he expects physicians to respond to recommendations prior to the following monthly visit. Review of a policy titled Medication- Drug Regimen Review dated December 2017 indicated: The Pharmacy Consultant drug regimen review and nursing medication documentation review reports are processed as follows: The physician provides a written response to the home after the report is sent. The physician's response is provided to the Pharmacy Consultant for review and then filed by the home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no stated time frames in the policy. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observations, interviews, and record reviews, 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 8 residents (Resident #5 and #20) and 4 of 8 staff (CNA A, CNA B, LVN C and LVN D) reviewed for infection control. The facility failed to ensure CNA A and CNA B followed enhanced barrier precautions when providing care to Resident #5 on 3/03/2025. The facility failed to ensure LVN C and LVN D followed enhanced barrier precautions when providing care to Resident #20 on 3/04/2025. This failure could place residents at risk for cross contamination and infection. Findings included: 1. Record review of Resident #5's facility face sheet dated 3/04/2025 revealed Resident #5 was a [AGE] year-old male and was admitted on [DATE] with a diagnosis of dementia. Record review of Resident #5's quarterly MDS assessment dated revealed Resident #5 had a BIMS score of 14 indicating intact cognition. Record review of Resident #5's physician order dated 12/17/2024 revealed Resident #5 had an order for EBP twice daily. Record review of Resident #5's comprehensive care plan dated 12/17/2024 revealed Resident #5 required enhanced barrier precautions and to follow facility infection control policy. During an observation and interview on 3/03/25 at 9:30 am, Resident #5 had a pink dot by his name next to the door. Resident #5 said he thought the pink dot was for the staff to put on a gown when giving him care. He said the staff usually did, but sometimes they forgot. During an observation on 3/03/25 at 9:40 AM, Resident # 5 was transferred by CNA A and CNA B. Neither CNA applied PPE for resident care. During an interview on 3/03/2025 at 3:30 pm, CNA A said she had been trained on EBP and the pink dot on the name was her way of knowing a resident required EBP. She said she got nervous and forgot. She said by not using PPE for resident care it could cause a spread of infection. During an interview on 3/03/25 at 3:33 pm CNA B said EBP was when a resident needed PPE for a reason such as wounds, catheter, and feeding tube . She said Resident #5 had a pink sticker indicating EBP but was not sure what for and she should have put on PPE but forgot. She said by not following EBP, infections could spread. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 - Some	2. Record review of Resident #20's facility face sheet dated 3/04/2025 revealed Resident #20 was an [AGE] year old female and was admitted on [DATE] with diagnosis of aneurysm of descending aorta (bulge in the artery). Record review of Resident #20's quarterly MDS assessment dated [DATE] revealed Resident #20 had a BIMS of 9 indicating impaired cognition. Record review of Resident #20's physicians order dated 5/01/2024 revealed Resident #20 had an order for EBP twice daily. Record review of Resident #20's comprehensive care plan dated 5/01/2024 revealed Resident #20 required EBP during contact care. During an observation on 3/04/25 at 8:42 am, Resident #20 had a pink dot by her name next to the door indicating EBP. During an observation on 3/04/25 at 8:44 AM, LVN C and LVN D was in Resident # 20's room assessing Resident #20's oral cavity. Both were in contact with the resident and her linen with no PPE in place. During an interview on 3/04/24 at 8:45 am, LVN C said Resident #20 had a pink dot on her name plate and required EBP for resident care. She said she thought she only needed gloves and not a gown. She said she had been trained on EBP and got confused. She said not following EBP could cause the spread of infections. During an interview on 3/04/25 at 8:47 am, LVN D said she had received training on EBP and any resident with a pink dot outside their room, they had to apply gloves and a gown. She said she was only going to look inside Resident #20's mouth but when she was in contact with Resident #20, she should have put on a gown and gloves. She said by not following EBP it could spread infections. During an interview on 03/05/25 at 8:50 am, the DON said she was also the infection prevention nurse and was responsible for the infection control program and training. She said she and the charge nurses were responsible for making sure all staff and visitors were following the enhanced barrier precautions. She said training on EBP was completed on hire, annually, and as needed. She said if EBP was not followed, it could cause the spread of infection. She stated she would retrain all staff on infection control measures and EBP. During an interview on 03/05/25 at 9:16 am, the Administrator said the DON was the infection prevention nurse and responsible for ensuring all staff were following infection control measures. She said staff were trained on infection control on hire, annually, and as needed, and she expected them to follow infection control measures. She said by not following EBP, infections could spread. She said going forward, she would oversee that all staff were retrained on EBP and that it was followed. Record review of staff in-services dated 12/17/2024 and 5/07/2024 revealed staff had been trained on EBP. Record review of a facility policy titled Infection Control Precautions dated 3/2024 revealed, .For residents for whom EBP are indicated: dressing, bathing, transferring, providing hygiene .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and sanitary environment for 1 of 1 dining room (main dining room) and resident room [ROOM NUMBER]. 1. The facility failed to clean the main dining room ceiling fans (4) and vents (4). 2. The facility failed to maintain sheetrock and paint on the dining room walls and ceiling. 3. The facility failed to repair 3 obstructed/fogged windows in the main dining room. 4. The facility failed to repair a missing tile and broken floor tile in room [ROOM NUMBER]. These failures could place residents at risk for exposure to an unclean, unsanitary environment, risk of falls and other injuries due to an unsafe environment. Findings included: During an observation on 03/03/25 at 12:30 PM until 1:15 PM in the dining room, revealed wall vents on right side wall and 4 ceiling fans blades were covered with think dust and dirt. On the left side of the dining room, there were 3 windows with obstructed views due to fogging between the glass panes . There were two areas of patched bare sheetrock that had no paint near the therapy entrance to the dining room and the main dining entrance. There were cracked floor tiles and a missing green floor tile in front of the therapy entrance to the dining room . There was an area of patched sheetrock on the ceiling that had no paint. Near the patched area was a red/brown splash on the ceiling. The 4 air vents on the right side of the dining room were dirty with lint-dust. During an observation on 03/03/2025 at 3:00 PM of resident room [ROOM NUMBER], revealed a missing and a broken floor tile in the middle of the room During an observation of the dining room and interview on 03/04/2025 at 8:00 AM, the Dietary Manager looked at the ceiling fan above the dining tables and said it was her responsibility to make sure the dining room was clean and maintained for the residents' dining experience. She said she had not noticed the ceiling fans being dirty with dust buildup and she would get the Maintenance Man and housekeeping to clean them. She said that the dust could fall onto the resident's plate while eating. The Dietary Manager said she had not requested the broken floor tiles, sheetrock on the ceiling and walls to be repaired and painted. She said she would put in a request. She said not maintaining the environment could cause the residents to have a decreased dining experience. During an interview on 03/04/25 08:15 AM, Housekeeper E said the red substance splashed on the ceiling should be cleaned and the ceiling fan should be cleaned. He said the dust could fall off the blades and land in the residents' food. He said not cleaning the dining room could decrease the residents' dining experience. He said he had never noticed the fogged windows in the dining room and that the residents could not see out. This could affect the residents' quality of life. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/04/25 09:00 AM, the Maintenance Man said there was a logbook for staff to log requests for repairs. He said he had repaired the sheetrock in the dining room ceiling and walls but had not painted it yet. He said he just didn't have the time. He said the risk to the resident was the area could not be cleaned effectively. The Maintenance Man said he had never paid any attention to the fogged windows, and he had not requested for the windows to be replaced. He said he in the middle of the room the air vents when needed and changed out vent filters usually monthly. He said the staff log maintenance needs in a book at the nurses' station and he checks it daily for issues. During an interview on 3/05/2025 at 9:45 AM, the Administrator said it was the policy of the facility to maintain a clean, sanitary, and orderly environment. She said that not maintaining the environment could lead to decreased quality of life, infections, and hazards. She said the Maintenance Director would be responsible for repairing broken items, such as sheetrock and Housekeeping would be responsible for cleaning the fans. She said the facility was looking at remodeling the dining room with replacement of the windows. Record Review of a maintenance work order book, requests for maintenance dated 1/01/2025 to 3/04/2025 indicated no requests for walls, ceilings, vents, or windows rooms to be repaired. Record Review of the facility's policy entitled, Infection Control-Environmental Rounds, dated 12/2018 indicated: Policy: It is the policy of this home that the Administrator or other appropriate designee completes environmental rounds on a regular basis. Procedure: Environmental rounds will be an integral part of the daily routine and will be performed regularly throughout the entire home, with attention to all units and departments as needed. (It is suggested that a selection of individual units as well as the dietary, laundry, and housekeeping departments be specifically identified for closer scrutiny each month.) The Administrator/designee will identify areas of noncompliance. Areas of concern and the corrective action will be discussed during stand up and with the supervisors of each area. The corrective action will be completed by the supervisor, and completion relayed to the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 46273 Based on observations, interviews, and record reviews, the facility failed to ensure it formulated, adopted, and enforced policies regarding smoking, smoking areas, and smoking safety that also consider non-smoking residents for 1 of 1 smoking area reviewed for smoking safety. The facility failed to ensure cigarette butts were not discarded into the regular trash can along with flammable products on 3/3/35 and 3/4/25. This failure could place residents at risk of injury, burns, and an unsafe smoking environment. Findings include: During an observation on 3/3/25 at 3:50 pm, a large, silver metal trash can was observed in smoking area, it was lined with a clear plastic liner. When the lid to trash can was opened, multiple cigarette butts were observed along with cigarette boxes, multiple plastic bags, and other paper trash. During an observation and interview on 3/4/25 at 8:36 am, cigarette butts, along with cigarette boxes, plastic bags and other paper trash were still observed to be in large, silver metal trash can in smoking area. Regional MDS Nurse said Maintenance was responsible for the ashtrays and trash cans in the smoking area. She looked inside of the trash can and said she also saw the cigarette butts in the trash can. She said she felt like someone was just emptying the ashtrays in there. She said it could be a fire hazard if cigarette butts were put in the regular trash cans. During an interview on 3/5/35 at 9:06 am, the Administrator said ashtrays should always be emptied into the red metal trashcan. She said maintenance was responsible for emptying ashtrays. She said it could be a fire hazard if ashtrays were emptied into the regular trash. She said she had already begun in-services and would be educating all staff on proper disposal of cigarette butts from ashtrays. Record review of the facility's policy titled Smoking dated 12/2018 indicated that it did not address safe disposable of cigarette butts.