| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident had a right to a dignified existence and self-determination that promotes enhancement of his or her quality of life, recognizing each resident's individuality for one of eight residents (Resident #1) reviewed for resident rights.<br><br>The facility failed to ensure Resident #1's right to go to the hospital on [DATE] was followed by RN A. Police had to contact EMS for Resident #1 requesting to go to the hospital for a possible blood clot.<br><br>The failure could place residents at risk of a loss of self-determination and dignity.<br><br>Findings included:<br><br>Review of Resident #1's face sheet undated reflected Resident #1 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] from the hospital. Resident #1 had diagnoses of acute embolism and thrombosis of right femoral vein (presence of a blood clot in the femoral vein of the right leg), atrial fibrillation (irregular heartbeat), acute embolism and thrombosis of right lower extremity bilateral (presence of blood clots in the deep veins in both legs), chronic pulmonary edema (the buildup of fluid in your lungs), peripheral vascular disease (condition where blood vessels outside the heart and brain are affected, reducing blood flow to the limbs). Resident #1 was his own responsible party.<br><br>Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS of 15 indicating he was cognitively intact. Resident #1 required set up assistance to independent with ADLs.<br><br>Review of Resident #1's Comprehensive Care Plan reflected the following:<br><br>-dated 04/21/25 Resident will call [transportation] to go to the hospital wanting IV pain medication. Even when offering his pain medication he has on hand.<br><br>-dated 06/02/25 high probability of [deep vein thrombosis] to lower extremities. Refuses to take any type of anticoagulant. Intervention included to notify provider and send resident to ER when [complaint of shortness of breath].<br><br>(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 |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -dated 06/02/25 Risk for deep vein thrombosis. Interventions include evaluate legs for swelling and monitor legs for changes in skin color, temperature.<br><br>Review of Resident #1's Nurse progress note by RN A dated 05/31/25 reflected the following: [LVN D] notified this nurse that resident wanted to talk. when this nurse arrived at resident room. resident stated, I said to that other nurse that when I need to go he hospital . I need to go. this nurse said, alright you can go then, resident interrupted nurse and stated, you know what get out of here. now! get the hell out of here. this nurse said OKAY and stared walking down the hall. Resident followed this nurse down the hall and became aggressive and started yelling at this nurse, you f****** bitch I will destroy you. I will ruin you. f*** you. resident waving hands in the air. This nurse left and went to shelter in 300 unit, then police were called. nurse asked the police to speak to resident because of the potential for scalation and that, he might physically attack this nurse later. this nurse also asked the police to request resident to delete the videos on his phone that he have been recording of this nurse on the previous morning in the lobby area of this facility. resident left facility via EMS. nurse was not notified of this.<br><br>Review of local police call record dated 05/31/25 at 6:14 PM a call for a welfare check at the facility reflected patient is being aggressive towards staff with caller as the RN Nurse for night shift who is concerned for her safety. The caller reported patient verbally assaulted the caller. At 6:34 PM police arrived to the facility and 6:45 PM a request for EMS for patient transport possible blood clot. EMS notified. EMS transport one at 7:00 PM.<br><br>Review of Resident #1's EMS record dated 05/31/25 reflected Patient was noted to be sitting on the edge of the bed with the left leg swollen. Patient stated that he was having some sudden trouble breathing with leg pain as well. Patient stated that he has history of blood clots and that today it was getting worse. Patient states that it's gotten even more unbearable for the last 45 minutes when his shortness of breath started. Patient stated that he tried telling the nurse staff but they would not take him seriously. Patient then stated he got irritated and raise his voice at the staff and law enforcement was called .Medic 2 transported one patient code [emergent] to [hospital] without incident.<br><br>Review of Resident #1's hospital records reflected Resident #1 was admitted to the hospital on [DATE] from nursing home with diagnoses of bilateral leg pain, factor V Leiden deficiency (inherited disorder that increases the risk of developing blood clots) and chronic bilateral lower extremity DVTs. Resident #1 was brought to the [emergency department] from the nursing nurse via EMS with a chief complaint of worsening of his lower extremity edema with pain associated with worsening dyspnea over the last 2 days .He became concerned for new DVT probably [pulmonary embolism] because of his shortness of breath, requested EMS . In the [emergency department] venous dopplers currently ordered but are pending. CT angiogram of the chest revealed no pulmonary embolism .Labs include a CBC that revealed a mild normocytic anemia .Patient was initially on a heparin drip pending the venous doppler. He is being admitted for further management .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and Interview with Social Worker and Resident #1 on 06/03/25 at 9:59 AM revealed Resident #1 was in his room sitting on his bed. Resident #1 stated he wanted the social worker to stay in the room. Resident #1 stated on 05/31/25 he asked to speak to RN A. He stated RN A came to his room and he told her he needed to go to the hospital for shortness of breath and leg pain. Resident #1 stated RN A refused to send him to the hospital on [DATE] at the beginning of her shift and RN A did not care what happened to him. He stated the police were called to the facility by staff. He stated the police called EMS for him noticing he was short of breath. He stated the EMTs took me to the hospital for possible blood clot. He stated he was complaining of shortness of breath and leg pain. He stated RN A would not even print off his face sheet so he could have it when EMTs transporting him to the hospital. He stated he tried to do the right thing by letting RN A know he needed to go to the hospital. He stated he returned to the facility from the hospital yesterday on 06/02/25.<br><br>Interview on 06/03/25 at 10:35 AM with DON revealed she received a phone call on 05/31/25 from RN A, but it was not reported to her of Resident #1 wanting to go to the hospital. She stated at 6:38 pm she spoke to CNA C about RN A calling the police on Resident #1 but did not know why RN A called the police. DON stated she reached out to RN A who told her Resident #1 was being aggressive towards her and she was afraid of Resident #1. DON stated she was not notified about Resident #1 wanting to go to the hospital. She further stated she was not informed Resident #1 was sent to the hospital. She stated she should have been notified of Resident #1 being sent to the hospital. DON stated she did not find out Resident #1 had been sent to the hospital or in the hospital until 06/02/25 when she was at the facility. She stated she reached out to Resident #1 on 06/02/25 via telephone who reported to her about RN A refusing to send him to the hospital on [DATE] when he reported having trouble breathing and needing to go to the hospital.<br><br>Interviews on 06/03/25 at 1:11 PM with CNA C revealed on 05/31/25 Resident #1 was concerned about leg pain and swollen leg thought he might have a blood clot. She stated Resident #1 reported to her he wanted to be sent to hospital CNA C stated Resident #1 told her that he tried to do it their way by notifying RN A of needing to go to the hospital so they can send him to hospital but Resident #1 stated RN A blew him off. CNA C stated she did not have an opportunity to report Resident #1 wanting to be send to the hospital to LVN B because she got distracted when the police arrived to the facility. She stated Resident #1 went back to his room and police contacted EMT to send him to the hospital. She stated she did not know if LVN B was aware of Resident #1 wanting to go to the hospital.<br><br>Interview on 06/04/25 at 11:05 AM with Police Officer H revealed the police officer who was dispatched to the facility on [DATE] worked the night shift. He stated he would leave a message to call surveyor. He stated based on his review of the report it reflected on 05/31/25 a nurse from the facility called to report Resident #1 having a verbal altercation with nurse. He reviewed the call details report reflecting Resident #1 complained of leg pain when police arrived at the facility and police notified EMTs to send Resident #1 to the hospital.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/04/25 at 8:44 PM with LVN D revealed she was not asked to be Resident #1's charge nurse on 05/31/25. She stated the police officer asked her to print off Resident #1's face sheet but did not understand why RN A was not more involved in Resident #1 being sent to the hospital. She stated she did not know why Resident #1 was sent to the hospital on [DATE]. She stated she did not make any notifications of Resident #1 going to the hospital since he was RN A's resident on 05/31/25. She stated as the charge nurse if a resident reports to her wanting to go to the hospital, she would assess, find out more information about what was going on with resident and take vitals. She stated residents have a right to go to the hospital if he or she wants to. She stated she would contact the physician to report her assessment of the resident and what was going on with resident. She stated if a resident wants to go to the hospital she would report it to the physician and DON.<br><br>Interview on 06/05/25 at 9:14 AM with DON revealed RN A should have notified the physician and if resident wanted to be sent out to the hospital to send resident out to the hospital. She stated Resident #1 was his own responsible party. She stated Resident #1 was admitted to the hospital on [DATE]. She stated Resident #1 had a history of DVT in a previous hospitalization.<br><br>Interview on 06/05/25 at 9:33 AM with Resident #1's MD revealed if resident wanted to go to the hospital, the nurse will contact EMS for transportation. He stated the risk to the resident could be potential risk of pulmonary embolism or heart attack. He stated Resident #1 could have had complications but he was not discharged until 06/02/25 to rule out DVT and blood clot for Resident #1.<br><br>Interview on 06/05/25 at 10:17 AM with LVN D revealed Resident #1 told her he needed to talk to RN A but did not tell him what was going on. She reported to RN A at shift change which was 6:00 PM on 05/31/25 that Resident #1 wanted to talk to him. LVN D stated she was not informed Resident #1 wanted to go to the hospital and was not aware of any change of condition for Resident #1.<br><br>Interview on 06/07/25 at 11:18 AM with RN A revealed LVN D reported to her Resident #1 wanted him to go see him at beginning of her shift at 6 PM. She stated she found it odd he wanted to talk to her because she stated she stayed out of his room, she did not like to deal with him and if he walking down the hall. She went the other way. She stated when she entered Resident #1's room. RN A stated he told her he needed to go to the hospital and she told him you can go. RN A stated Resident #1 started yelling at her, told her to get the hell out of his room. She stated she left his room and he followed her down the hall saying who the hell are you, I am going to destroy you. RN A stated she did not know what Resident #1 was complaining of and did not have a chance to ask any questions. She stated she did not have a chance to assess him or ask him more questions to find out what he wanted to go to the hospital. LVN D stated she went to shelter on the secure unit and called the police to inform of Resident #1's aggression towards her. She stated she needed to administer her medications to the residents on his hall and was afraid he might attack her so she called the police. RN A stated she called the police after she sheltered on the secure unit and it took like 20 to 30 minutes for them to arrive. She stated she did not inform the police about Resident #1 wanting to go to the hospital. She did not inform anyone about Resident #1 wanting to go to the hospital. She stated the police called for Resident #1 to be sent out to the hospital. She stated the DON called me on 05/31/25 to find out why she called the police. She stated she did not inform anyone about Resident #1 going to the hospital. She stated Resident #1 did have chronic DVT history. She stated when she was contacted by the facility on 06/02/25 she told them she quit because she knew Resident #1 would be back at the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility's policy Resident Rights last revised February 2021 reflected employees shall treat all residents with kindness, respect and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; .e. self-determination .s .participate in decision-making regarding his or her care . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's physician when there was a significant change in the physical status for one (Resident #1) of six residents reviewed for notification of changes.<br><br>RN A failed to notify the physician of Resident #1 being sent to the hospital on [DATE].<br><br>This failure could place residents at risk for not notifying the physician for a change in condition and hospitalization.<br><br>Findings included:<br><br>Review of Resident #1's face sheet undated reflected Resident #1 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] from the hospital. Resident #1 had diagnoses of acute embolism and thrombosis of right femoral vein (presence of a blood clot in the femoral vein of the right leg), atrial fibrillation (irregular heartbeat), acute embolism and thrombosis of right lower extremity bilateral (presence of blood clots in the deep veins in both legs), chronic pulmonary edema (the buildup of fluid in your lungs), peripheral vascular disease (condition where blood vessels outside the heart and brain are affected, reducing blood flow to the limbs). Resident #1 was his own responsible party.<br><br>Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS of 15 indicating he was cognitively intact. Resident #1 required set up assistance to independent with ADLs.<br><br>Review of Resident #1's Comprehensive Care Plan reflected the following:<br><br>-dated 04/21/25 Resident will call [transportation] to go to the hospital wanting IV pain medication. Even when offering his pain medication he has on hand.<br><br>-dated 06/02/25 high probability of [deep vein thrombosis] to lower extremities. Refuses to take any type of anticoagulant. Intervention included to notify provider and send resident to ER when [complaint of shortness of breath].<br><br>-dated 06/02/25 Risk for deep vein thrombosis. Interventions include evaluate legs for swelling and monitor legs for changes in skin color, temperature.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's Nurse progress note by RN A dated 05/31/25 reflected the following: [LVN D] notified this nurse that resident wanted to talk. when this nurse arrived at resident room. resident stated, I said to that other nurse that when I need to go he hospital . I need to go. this nurse said, alright you can go then, resident interrupted nurse and stated, you know what get out of here. now! get the hell out of here. this nurse said OKAY and stared walking down the hall. Resident followed this nurse down the hall and became aggressive and started yelling at this nurse, you f****** bitch I will destroy you. I will ruin you. f*** you. resident waving hands in the air. This nurse left and went to shelter in 300 unit, then police were called. nurse asked the police to speak to resident because of the potential for scalation and that, he might physically attack this nurse later. this nurse also asked the police to request resident to delete the videos on his phone that he have been recording of this nurse on the previous morning in the lobby area of this facility. resident left facility via EMS. nurse was not notified of this.<br><br>Review of local police call record dated 05/31/25 at 6:14 PM a call for a welfare check at the facility reflected patient is being aggressive towards staff with caller as the RN Nurse for night shift who is concerned for her safety. The caller reported patient verbally assaulted the caller. At 6:34 PM police arrived to the facility and 6:45 PM a request for EMS for patient transport possible blood clot. EMS notified. EMS transport one at 7:00 PM.<br><br>Review of Resident #1's EMS record dated 05/31/25 reflected Patient was noted to be sitting on the edge of the bed with the left leg swollen. Patient stated that he was having some sudden trouble breathing with leg pain as well. Patient stated that he has history of blood clots and that today it was getting worse. Patient states that it's gotten even more unbearable for the last 45 minutes when his shortness of breath started. Patient stated that he tried telling the nurse staff but they would not take him seriously. Patient then stated he got irritated and raise his voice at the staff and law enforcement was called .Medic 2 transported one patient code [emergent] to [hospital] without incident.<br><br>Review of Resident #1's hospital records reflected Resident #1 was admitted to the hospital on [DATE] from nursing home with a history of factor V Leiden deficiency (inherited disorder that increases the risk of developing blood clots) with a history of chronic bilateral lower extremity DVTs .who was brought to the [emergency department] from the nursing nurse via EMS with a chief complaint of worsening of his lower extremity edema with pain associated with worsening dyspnea over the last 2 days .He became concerned for new DVT probably [pulmonary embolism] because of his shortness of breath, requested EMS .In the [emergency department] venous dopplers currently ordered but are pending. CT angiogram of the chest revealed no pulmonary embolism .Labs include a CBC that revealed a mild normocytic anemia .Patient was initially on a heparin drip pending the venous doppler. He is being admitted for further management .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and Interview on 06/03/25 at 9:59 AM with Social Worker revealed Resident #1 was in his room sitting on his bed. Resident #1 stated he wanted the social worker to stay in the room. Resident #1 stated on 05/31/25 he asked to speak to RN A. He stated RN A came to his room and he told her he needed to go to the hospital for shortness of breath and leg pain. Resident #1 stated RN A refused to send him to the hospital on [DATE] at the beginning of her shift and RN A did not care what happened to me. He stated the police were called to the facility by staff. He stated the police called EMS for him noticing he was short of breath. He stated the EMTs took me to the hospital for possible blood clot. He stated he was complaining of shortness of breath and leg pain. He stated RN A would not even print off his face sheet so he could have it when EMTs transporting him to the hospital. He stated he tried to do the right thing by letting RN A know he needed to go to the hospital. He stated he returned back to the facility from the hospital yesterday on 06/02/25.<br><br>Interview on 06/03/25 at 10:35 AM with DON revealed she received a phone call on 05/31/25 from RN A, but it was not reported to her of Resident #1 wanting to go to the hospital. She stated at 6:38 pm she spoke to CNA C about RN A calling the police on Resident #1 but did not know why RN A called the police. DON stated she reached out to RN A who told her Resident #1 was being aggressive towards her and she was afraid of Resident #1. DON stated she was not notified about Resident #1 wanting to go to the hospital. She further stated she was not informed Resident #1 was sent to the hospital. She stated she should have been notified of Resident #1 being sent to the hospital. DON stated she did not find out Resident #1 had been sent to the hospital or in the hospital until 06/02/25 when she was at the facility. She stated she reached out to Resident #1 on 06/02/25 via telephone who reported to her about RN refusing to send him to the hospital on [DATE] when he reported having trouble breathing and needing to go to the hospital.<br><br>Interviews on 06/03/25 at 1:11 PM with CNA C revealed on 05/31/25 Resident #1 was concerned about leg pain and swollen leg thought he might have a blood clot. She stated Resident #1 reported to her he wanted to be sent to hospital CNA C stated Resident #1 told her that he tried to do it their way by notifying RN A of needing to go to the hospital so they can send him to hospital but Resident #1 stated RN A blew him off. CNA C stated she did not have an opportunity to report Resident #1 wanting to be send to the hospital to LVN B because she got distracted when the police arrived to the facility. She stated Resident #1 went back to his room and police contacted EMT to send him to the hospital. She stated she did not know if LVN B was aware of Resident #1 wanting to go to the hospital.<br><br>Interview on 06/04/25 at 11:05 AM with Police Officer H revealed the police officer who was dispatched to the facility on [DATE] worked the night shift. He stated he would leave a message to call surveyor. He stated based on his review of the report it reflected on 05/31/25 a nurse from the facility called to report Resident #1 having a verbal altercation with nurse. He reviewed the call details report reflecting Resident #1 complained of leg pain when police arrived at the facility and police notified EMTs to send Resident #1 to the hospital.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/04/25 at 8:44 PM with LVN D revealed she was not asked to be Resident #1's charge nurse on 05/31/25. She stated the police officer asked her to print off Resident #1's face sheet but did not understand why RN A was not more involved in Resident #1 being sent to the hospital. She stated she did not know why Resident #1 was sent to the hospital on [DATE]. She stated she did not make any notifications of Resident #1 going to the hospital since he was RN A's resident on 05/31/25. She stated as the charge nurse if a resident reports to her wanting to go to the hospital, she would assess, find out more information about what was going on with resident and take vitals. She stated residents have a right to go to the hospital if he or she wants to. She stated she would contact the physician to report her assessment of the resident and what was going on with resident. She stated if a resident wants to go to the hospital she would report it to the physician and DON.<br><br>Interview on 06/05/25 at 9:14 AM with DON revealed she expected the RN A to assess resident including head to toe, vital, and asking to find out more about resident's change of condition. She stated RN A should have notified the physician and if resident wanted to be sent out to the hospital to send resident out to the hospital. She stated Resident #1 was his own responsible party. She stated Resident #1 was admitted to the hospital on [DATE]. She stated Resident #1 had a history of DVT in a previous hospitalization.<br><br>Interview on 06/05/25 at 9:33 AM with Resident #1's MD revealed he could not recall if he was notified about Resident #1 being sent to the hospital on [DATE]. He stated he expected the nurse to assess the resident including taking vitals and listening to lungs. He expected the nurse to find out more information of why Resident #1 wanted to be sent to the hospital. Resident #1's MD stated should call the on-call physician to notify of Resident #1 symptoms and change of condition. He stated if resident wanted to go to the hospital, the nurse will contact EMS for transportation. He stated the risk to the resident could be potential risk of pulmonary embolism or heart attack. He stated Resident #1 could have had complications but he was kept in the hospital until the DVT and blood clot were ruled out.<br><br>Interview on 06/05/25 at 10:17 AM with LVN D revealed Resident #1 told her he needed to talk to RN A but did not tell him what was going on. She reported to RN A at shift change which was 6:00 PM on 05/31/25 that Resident #1 wanted to talk to her. LVN D stated she was not informed Resident #1 wanted to go to the hospital and was not aware of any change of condition for Resident #1.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/07/25 at 11:18 AM with RN A revealed LVN D reported to her Resident #1 wanted him to go see him at beginning of her shift at 6 PM. She stated she found it odd he wanted to talk to her because she stated she stayed out of his room, she did not like to deal with him and if he walking down the hall I go the other way. She stated when she entered Resident #1's room. RN A stated he told he needed to go to the hospital and she told him you can go. RN A stated Resident #1 started yelling at her, told her to get the hell out of his room. She stated she left his room and he followed her down the hall saying who the hell are you, I am going to destroy you. RN A stated she did not know what Resident #1 was complaining of and did not have a chance to ask any questions. She stated she did not have a chance to assess him or ask him more questions to find out what he wanted to go to the hospital. LVN D stated she went to shelter on the secure unit and called the police to inform of Resident #1's aggression towards her. She stated she needed to administer her medications to the residents on his hall and was afraid he might attack me so she called the police. RN A stated she called the police after she sheltered on the secure unit and it took like 20 to 30 minutes for them to arrive. She stated she did not inform the police about Resident #1 wanting to go to the hospital. She did not inform anyone about Resident #1 wanting to go to the hospital. She stated the police called for Resident #1 to be sent out to the hospital. She stated the DON called me on 05/31/25 to find out why I called the police. She stated she did not inform anyone about Resident #1 going to the hospital. She stated Resident #1 did have chronic DVT history.<br><br>Review of facility's policy Change in a Resident's Condition or Status last revised April 2025 reflected the facility promptly notifies his or her attending physician .of changes in the resident's medical/mental condition and or status .The nurse will notify the resident's attending physician or physician on call when there has been a(an) .need to transfer resident to a hospital/treatment center .3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to protect a resident's right to be free from neglect for one (Resident #1) of 8 residents reviewed for resident neglect.<br><br>The facility failed to ensure Resident #1 was free from neglect by RN A on 05/31/25. RN A failed to perform an assessment on 05/31/25 when Resident #1 reported he needed to go to the hospital complaining of leg pain.<br><br>RN A failed to notify and follow-up to ensure Resident #1 was sent to the hospital.<br><br>RN A failed to notify the physician or any licensed nurse of Resident #1 requesting to go to the hospital. RN A called 911 to report Resident #1's behavior, but RN A failed to report Resident #1 wanted to go to the hospital on [DATE]. When police arrived at the facility on 05/31/25, RN A did not notify the police of Resident #1 wanting to go to the hospital or assist in sending Resident #1 to the hospital. The local police called EMS and Resident #1 was transferred to the emergency room. Resident #1 was admitted to the hospital on [DATE] and placed on a heparin drip as a precaution until test results were completed to rule out a DVT.<br><br>These failures resulted in an identification of an Immediate Jeopardy (IJ) on 06/05/25 at 5:10 PM. While the IJ was removed on 06/06/25 at 8:15 PM, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>These failures placed residents at risk for serious injuries, abuse, serious harm, and death.<br><br>Findings included:<br><br>Review of Resident #1's face sheet undated reflected Resident #1 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] from the hospital. Resident #1 had diagnoses of acute embolism and thrombosis of right femoral vein (presence of a blood clot in the femoral vein of the right leg), atrial fibrillation (irregular heartbeat), acute embolism and thrombosis of right lower extremity bilateral (presence of blood clots in the deep veins in both legs), chronic pulmonary edema (the buildup of fluid in your lungs), peripheral vascular disease (condition where blood vessels outside the heart and brain are affected, reducing blood flow to the limbs). Resident #1 was his own responsible party.<br><br>Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS of 15 indicating he was cognitively intact. Resident #1 required set up assistance to independent with ADLs.<br><br>Review of Resident #1's Comprehensive Care Plan reflected the following:<br><br>-dated 04/21/25 Resident will call [transportation] to go to the hospital wanting IV pain medication. Even when offering his pain medication he has on hand.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -dated 06/02/25 high probability of [deep vein thrombosis] to lower extremities. Refuses to take any type of anticoagulant. Intervention included to notify provider and send resident to ER when [complaint of shortness of breath].<br><br>-dated 06/02/25 Risk for deep vein thrombosis. Interventions include evaluate legs for swelling and monitor legs for changes in skin color, temperature.<br><br>Review of Resident #1's Nurse progress note by RN A dated 05/31/25 reflected the following: [LVN D] notified this nurse that resident wanted to talk. when this nurse arrived at resident room. resident stated, I said to that other nurse that when I need to go he hospital . I need to go. this nurse said, alright you can go then, resident interrupted nurse and stated, you know what get out of here. now! get the hell out of here. this nurse said OKAY and stared walking down the hall. Resident followed this nurse down the hall and became aggressive and started yelling at this nurse, you f****** bitch I will destroy you. I will ruin you. f*** you. resident waving hands in the air. This nurse left and went to shelter in 300 unit, then police were called. nurse asked the police to speak to resident because of the potential for scalation and that, he might physically attack this nurse later. this nurse also asked the police to request resident to delete the videos on his phone that he have been recording of this nurse on the previous morning in the lobby area of this facility. resident left facility via EMS. nurse was not notified of this.<br><br>Review of local police call record dated 05/31/25 at 6:14 PM a call for a welfare check at the facility reflected patient is being aggressive towards staff with caller as the RN Nurse for night shift who is concerned for her safety. The caller reported patient verbally assaulted the caller. At 6:34 PM police arrived to the facility and 6:45 PM a request for EMS for patient transport possible blood clot. EMS notified. EMS transport one at 7:00 PM.<br><br>Review of Resident #1's EMS record dated 05/31/25 reflected Patient was noted to be sitting on the edge of the bed with the left leg swollen. Patient stated that he was having some sudden trouble breathing with leg pain as well. Patient stated that he has history of blood clots and that today it was getting worse. Patient states that it's gotten even more unbearable for the last 45 minutes when his shortness of breath started. Patient stated that he tried telling the nurse staff but they would not take him seriously. Patient then stated he got irritated and raise his voice at the staff and law enforcement was called .Medic 2 transported one patient code [emergent] to [hospital] without incident.<br><br>Review of Resident #1's hospital records reflected Resident #1 was admitted to the hospital on [DATE] from nursing home with a history of factor V Leiden deficiency (inherited disorder that increases the risk of developing blood clots) with a history of chronic bilateral lower extremity DVTs .who was brought to the [emergency department] from the nursing nurse via EMS with a chief complaint of worsening of his lower extremity edema with pain associated with worsening dyspnea over the last 2 days .He became concerned for new DVT probably [pulmonary embolism] because of his shortness of breath, requested EMS .In the [emergency department] venous dopplers currently ordered but are pending. CT angiogram of the chest revealed no pulmonary embolism .Labs include a CBC that revealed a mild normocytic anemia .Patient was initially on a heparin drip pending the venous doppler. He is being admitted for further management .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation and Interview on 06/03/25 at 9:59 AM with Social Worker revealed Resident #1 was in his room sitting on his bed. Resident #1 stated he wanted the social worker to stay in the room. Resident #1 stated on 05/31/25 he asked to speak to RN A. He stated RN A came to his room and he told her he needed to go to the hospital for shortness of breath and leg pain. Resident #1 stated RN A refused to send him to the hospital on [DATE] at the beginning of her shift and RN A did not care what happened to me. He stated he did get upset yelled at RN A. He stated the police were called to the facility by staff. He stated the police called EMS for him noticing he was short of breath. He stated the EMTs took me to the hospital for possible blood clot. He stated he was complaining of shortness of breath and leg pain. He stated on 05/31/25 he told CNA C about RN A refusing to send him to the hospital. He stated RN A would not even print off his face sheet so he could have it when EMTs transporting him to the hospital. He stated he tried to do the right thing by letting RN A know he needed to go to the hospital. He stated he returned back to the facility from the hospital yesterday on 06/02/25. He stated the Administrator was aware of the allegation and he was told by Administrator that RN A would not be returning back to the facility.<br><br>Interview on 06/03/25 at 10:35 AM with DON revealed she received a phone call on 05/31/25 from RN A about not wanting to take care of Resident #1 anymore because he was being verbally aggressive towards me and asked if LVN B could take care of him. DON stated she advised RN A to inform LVN B to take care of Resident #1 for the rest of the shift. DON stated it was not reported to her of Resident #1 wanting to go to the hospital. She stated at 6:38 pm she spoke to CNA C about RN A calling the police on Resident #1 but did not know why RN A called the police. DON stated she reached out to RN A who told her Resident #1 was being aggressive towards her and she was afraid of Resident #1. DON stated she was not notified about Resident #1 wanting to go to the hospital. She further stated she was not informed Resident #1 was sent to the hospital. She stated she should have been notified of Resident #1 being sent to the hospital. DON stated she did not find out Resident #1 had been sent to the hospital or in the hospital until 06/02/25 when she was at the facility. She stated she reached out to Resident #1 on 06/02/25 via telephone who reported to her about RN refusing to send him to the hospital on [DATE] when he reported having trouble breathing and needing to go to the hospital. She stated she immediately reported the neglect allegation to the Administrator. She stated Administrator reached out to RN A who was suspended pending investigation on 06/02/25.<br><br>Interviews on 06/03/25 at 1:11 PM with CNA C revealed on 05/31/25 Resident #1 was concerned about leg pain and swollen leg thought he might have a blood clot. She stated Resident #1 reported to her he wanted to be sent to hospital CNA C stated Resident #1 told her that he tried to do it their way by notifying RN A of needing to go to the hospital so they can send him to hospital but Resident #1 stated RN A blew him off. CNA C stated she did not have an opportunity to report Resident #1 wanting to be send to the hospital to LVN B because she got distracted when the police arrived to the facility. She stated she contacted the DON via telephone on 05/31/25 about police in the facility and RN A had called the police on Resident #1. CNA C stated Resident #1 was walking slowly and was flustered with RN A. She stated Resident #1 went back to his room and police contacted EMT to send him to the hospital. She stated she did not know if LVN B was aware of Resident #1 wanting to go to the hospital. CNA C stated Resident #1 had issues with RN A but RN A was still Resident #1's nurse. She stated RN A would ask LVN B to give Resident #1 his medications. She stated her last in-service on abuse/neglect was about a couple weeks ago to maybe a month ago. She stated she had not been in-serviced on 05/31/25 or after on abuse/neglect policy including reporting. She stated she had not spoke to Administrator or DON to give them a statement about the incident on 05/31/25 with Resident #1.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/04/25 at 8:09 PM with CNA C revealed she reported to the DON about RN A not sending Resident #1 to the hospital when she reported to DON about RN A calling the police on Resident #1. She stated she should have called the Administrator who is the abuse coordinator immediately to report the allegation of neglect of Resident #1 reporting RN A did not send him to the hospital. She stated she was verbally counseled for failure to report the allegation to the Administrator immediately. She stated RN A worked the rest of her shift on 05/31/25 and worked on 06/01/25 night shift until 6 AM on 06/02/25.<br><br>Interview on 06/03/25 at 2:52 PM with Social Worker revealed Resident #1 reported on 05/31/25 to RN A he was short of breath and was concerned about a possible blood clot. She was not aware of RN A refusing to send him to the hospital until 06/03/25. Social Worker stated RN A had an attitude problem and Resident #1 reported to her RN A was mouthy to him.<br><br>Interview on 06/04/25 at 11:05 AM with Police Officer H revealed the police officer who was dispatched to the facility on [DATE] worked the night shift. He stated he would leave a message to call surveyor. He stated based on his review of the report it reflected on 05/31/25 a nurse from the facility called to report Resident #1 having a verbal altercation with nurse. He reviewed the call details report reflecting Resident #1 complained of leg pain when police arrived at the facility and police notified EMTs to send Resident #1 to the hospital.<br><br>Interview on 06/04/25 at 8:44 PM with LVN D revealed she had been administering Resident #1's medications to Resident #1 when RN A was assigned as his nurse for the last couple of weeks She stated RN A told her that she could not administer medications to Resident #1 and DON was aware of it. She stated she did not follow up with DON or the Administrator about RN A not administering Resident #1's medications on her shifts and requesting her to give Resident #1 his medications. She stated she was not asked to be Resident #1's charge nurse on 05/31/25. She stated the police officer asked her to print off Resident #1's face sheet but did not understand why RN A was not more involved in Resident #1 being sent to the hospital. She stated she did not know why Resident #1 was sent to the hospital. She stated she did not make any notifications of Resident #1 going to the hospital since he was RN A's resident on 05/31/25. She stated she heard Resident #1 cussing right after shift change but she did not really think anything of it since it stopped. She stated Resident #1 did verbally cuss out staff. She stated as the charge nurse if a resident reports to her wanting to go to the hospital, she would assess, find out more information about what was going on with resident and take vitals. She stated residents have a right to go to the hospital if he or she wants to. She stated she would contact the physician to report her assessment of the resident and what was going on with resident. She stated if a resident wants to go to the hospital she would report it to physician and DON.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/05/25 at 9:14 AM with DON revealed RN A called the police on Resident #1. She stated RN A told her Resident #1 was cussing and yelling at her. DON stated RN A told her she was in fear for her life so this is why she called the police. DON stated she expected the nurse to assess resident including head to toe, vital, and asking to find out more about resident's change of condition. She stated RN A should have notified the physician and if resident wanted to be sent out to the hospital to send resident out to the hospital. She stated Resident #1 was his own responsible party. She stated if she had known on 05/31/25 of RN A refusing to send Resident #1 to the hospital she would have reported an allegation of abuse/neglect to the Administrator immediately. She stated prior to this incident there had been customer service complaints of RN A's tone being rude. She stated Resident #1 did not like her. She was not aware of RN A not giving Resident #1 her medications when she was his charge nurse and having other nurses administer his medications. She stated Resident #1 was admitted to the hospital on [DATE]. She stated Resident #1 had a history of DVT in a previous hospitalization.<br><br>Interview on 06/05/25 at 9:33 AM with Resident #1's MD revealed he could not recall if he was notified about Resident #1 being sent to the hospital on [DATE]. He stated he expected the nurse to assess the resident including taking vitals and listening to lungs. He expected the nurse to find out more information of why Resident #1 wanted to be sent to the hospital. Resident #1's MD stated should call the on-call physician to notify of Resident #1 symptoms and change of condition. He stated Resident #1 had a history of calling Uber to go to hospital. He stated if resident wanted to go to the hospital, the nurse will contact EMS for transportation. He stated the risk to the resident could be potential risk of pulmonary embolism or heart attack.<br><br>Interview on 06/05/25 at 10:17 AM with LVN D revealed Resident #1 told her he needed to talk to RN A but did not tell him what was going on. She reported to RN A at shift change which was 6:00 PM on 05/31/25 that Resident #1 wanted to talk to him. LVN D stated she was not informed Resident #1 wanted to go to the hospital and was not aware of any change of condition.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/07/25 at 11:18 AM with RN A revealed LVN D reported to her Resident #1 wanted him to go see him at beginning of her shift at 6 PM. She stated she found it odd he wanted to talk to her because she stated she stayed out of his room, she did not like to deal with him and if he walking down the hall I go the other way. She stated when she entered Resident #1's room. RN A stated he told he needed to go to the hospital and she told him you can go. RN A stated Resident #1 started yelling at her, told her to get the hell out of his room. She stated she left his room and he followed her down the hall saying who the hell are you, I am going to destroy you. RN A stated she did not know what Resident #1 was complaining of and did not have a chance to ask any questions. She stated she did not have a chance to assess him or ask him more questions to find out what he wanted to go to the hospital. LVN D stated she went to shelter on the secure unit and called the police to inform of Resident #1's aggression towards her. She stated she needed to administer her medications to the residents on his hall and was afraid he might attack me so she called the police. RN A stated she called the police after she sheltered on the secure unit and it took like 20 to 30 minutes for them to arrive. She stated she did not inform the police about Resident #1 wanting to go to the hospital. She did not inform anyone about Resident #1 wanting to go to the hospital. She stated the police called for Resident #1 to be sent out to the hospital. She stated she had 2 incidents with Resident #1 when giving him his medications prior to 05/31/25 and Resident #1 got upset at her for opening the door and waking him up for his medications. She stated Resident #1 followed her and yelled at her by cussing her out. She stated she gave the other nurse on her shift to have the other nurse administer his medications. She stated she would follow-up with other nurse to see if it was given and documented it was given. She stated the DON called me on 05/31/25 to find out why I called the police. She stated she did not inform anyone about Resident #1 going to the hospital. She stated Resident #1 did have chronic DVT history. She stated when she was contacted by the facility on 06/02/25 she told them she quit because she knew Resident #1 would back at the facility.<br><br>Interview on 06/05/25 at 12:10 PM with Administrator revealed Resident #1 did have past issues with nurses about wanting to get medications on time. He stated Resident #1 did have history of being verbally aggressive to staff. DON reported to him on 06/02/25 of Resident #1 reporting RN A refused to send him to the hospital and police had to call EMS to send him to the hospital. The Administrator stated this was an allegation of neglect and possibly abuse so he reported it to HHSC. He stated he initiated the investigation and contacted RN A to suspend her pending investigation. He stated RN A refused to give a witness statement for the incident on 05/31/25 and RN A told him F*** this facility and F*** those residents. He stated he was not aware of RN A not giving Resident #1 his medications on her shift as the charge nurse and having the other nurse give the medications to Resident #1. He stated CNA C should have immediately notified me as the abuse coordinator on 05/31/25 of RN A refusing to send Resident #1 to the hospital. He stated RN A should have assessed Resident #1 and/or tell other nurse about Resident #1 wanting to go to hospital. He stated the failure to immediately report abuse or neglect to me could place residents at risk for resident abuse/neglect to continue and not be aware of abuse/neglect. He stated this placed the residents at risk for further abuse and neglect with allowing RN A to continue to work and could possibly do it to someone else.<br><br>Interview on 06/05/25 at 7:14 PM with Local Police Officer G revealed he did come out to the facility on [DATE]. He stated based on interviews with facility staff it seemed like Resident #1 did not seem to get along with RN A. He stated Resident #1 requested to the police to go to the hospital on [DATE] per a possible blood clot. He stated he called EMS and Resident #1 was sent out to the hospital.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of RN A's timecard for 05/31/25 reflected RN A worked from 05/31/25 at 5:43 PM to 6:14 AM on 06/01/25. On 06/01/25 at 5:43 PM to 6:21 PM on 06/02/25.<br><br>Review of facility's policy last revised September 2022 Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating reflected All reports of resident abuse (including injuries of unknown origin, neglect, exploitation or theft/misappropriation of property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management .Reporting allegations to the Administrator and Authorities 1. If resident abuse, neglect .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines . 6. Upon receiving any allegations of abuse, neglect .the administrator is responsible for ensuring what actions (if any) are needed for the protection of residents .12. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete .<br><br>On 06/05/25 at 5:10 PM, the Administrator and ADON were informed in person with DON and Regional VP on the phone of an IJ situation. The Administrator was provided the IJ template at this time.<br><br>The facility's plan of removal was accepted on 06/06/25 at 10:44 AM and reflected the following:<br><br>The facility failed to protect Resident #1's right to be free from neglect when RN A decided she would not provide care to resident #1 when she was assigned to the resident. This failure could place residents at risk for not having measures I place to protect them from serious harm, mental anguish, neglect or death.<br><br>The facility medical director was notified of the Immediate Jeopardy by the Facility Administrator on 06/05/2025.<br><br>Resident #1 was sent to the ER for evaluation and treatment on 5/31/25 and returned to the facility on [DATE].<br><br>RN A was suspended, pending investigation, by the DON and Facility Administrator on 6/2/25 and terminated from her position by the DON and Administrator on 6/3/25.<br><br>All staff were in-serviced on Abuse, Neglect, and Exploitation, Patient care assignments, resident change in condition, resident rights, and reporting Abuse and Neglect to the abuse coordinator/facility administrator immediately, beginning on June 2nd, 2025, and were completed on 06/05/2025. In-services were completed per the Director of Nursing. No staff or agency staff will be allowed in the facility until they are in-serviced by the ADON/ADMIN on Abuse, Neglect, and Exploitation and all other in-service requirements. Staff were in-serviced that it is a resident right to go to the hospital when they want. Staff were also in-serviced that they must assess patients prior to send them out. Staff were in-serviced by ADON that the MD must be notified on any change of condition immediately. DON/ADON will monitor and be responsible moving forward.<br><br>The facility DON began in-services for all nursing staff regarding resident care assignments and the responsibilities included in resident care assignments for nursing staff, notification to the physician if residents request to go to the hospital, notification to DON and Administrator if law enforcement are called to the facility, and resident assessment on 6/5/2025. All nursing staff will be in-serviced by the DON prior to the start of their next shift.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | DON and Administrator will interview 3 staff daily related to their understanding of the inservice education provided, for the next 4 weeks.<br><br>Admin/ADON conducted safe surveys with alert residents on 6/3/25<br><br>An Ad Hoc QAPI was held by the Regional VP of Operations, Facility Administrator, Director of Nursing, Regional Nurse Consultant, (medical director), and Asst. Director of Nurses on 06/05/2025 to review the alleged deficiency and plan.<br><br>Review of the IJ monitoring for the facility's plan of removal reflected the following:<br><br>Review of RN A's termination dated 06/02/25 reflected RN A was placed on suspension for neglect allegation and said she wasn't going to do that and stated she quit .[RN A] was very antagonistic towards the residents and other staff.<br><br>Interviews from 06/06/25 at 2:25 PM to 7:40 PM with four nurses from different shifts (LVN I, RN O, LVN Q and Agency LVN S) they had been in-serviced on abuse/neglect policy. All were knowledgeable of types of abuse/neglect and would report any allegations immediately to Administrator who was the abuse coordinator once the resident was safe.<br><br>Interviews from 06/06/25 at 2:42 PM to 7:20 PM with eight CNAs from different shifts (CNA J, CNA K, CNA L, CNA M, CNA N, CNA P, CNA R, and CNA T) revealed they had been in-serviced on abuse/neglect policy, resident rights and patient care responsibility. All were knowledgeable of types of abuse/neglect and would report any allegations immediately to Administrator who was the abuse coordinator once the resident was safe. All CNAs were aware of resident rights including resident right to go to the hospital. All stated if CNA became aware of allegation of nurse not sending a resident to the hospital or assessing a resident for a change of condition they would immediately notify the Administrator of the allegation. The CNAs stated they would notify the DON and Administrator if resident rights were violated. They were all knowledgeable of where to find contact information for the abuse coordinator.<br><br>Interviews from 06/06/25 at 3:40 PM to 7:26 PM with three facility staff (Activity Director, Dietary [NAME] U and Dietary Aide V) reflected they were in-serviced on abuse/neglect, reporting requirements of allegations and resident rights. All three staff were knowledgeable of types of abuse/neglect and would report any allegations immediately to Administrator who was the abuse coordinator once the resident was safe. They were aware of resident rights including resident right to go to the hospital. They stated they would notify the DON and Administrator if resident rights were violated. They were all knowledgeable of where to find contact information for the abuse coordinator.<br><br>Interview on 06/06/25 at 3:53 PM with Administrator revealed staff have been in-serviced from different shifts on abuse/neglect policy and reporting requirements. He stated all staff who have been in-serviced should be aware to notify him immediately of any allegations of abuse/neglect. He stated CNA C and LVN B have been in-serviced on abuse/neglect and reporting requirements to immediately report any allegations to him. He stated any staff who have not been in-serviced will be unable to work until in-serviced.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/06/25 at 4:41 PM with ADON revealed staff had been in-serviced on abuse/neglect. She was knowledgeable of types of abuse/neglect and would report any allegations to Administrator immediately once the resident was safe. She was knowledgeable of resident right. She stated LVN B had been in-serviced but she was unavailable to contact due to being on personal leave at this time. She stated LVN B would be in-serviced in person again to ensure her understanding of all the in-services when she returns back to work from her leave.<br><br>Review of In-services for Abuse/Neglect dated 06/02/25 to 06/05/25 reflected staff were in-serviced on abuse/neglect policy and reporting requirements.<br><br>Review of 2 of 2 resident clinical records (Resident #2 and #3) for change of condition and hospitalization revealed no concerns with abuse or neglect.<br><br>Review revealed CNA C and LVN B were verbally counseled for not reporting an allegation of abuse/neglect signed by employees on 06/04/25.<br><br>Review of Reporting of Abuse and Neglect dated 06/05/25 reflected if you feel, see or even think abuse or neglect is happening, immediately do the following: Get the resident or residents to safety. Immediately call the abuse coordinator [Administrator] with phone number provided.<br><br>An IJ was identified on 06/05/25. The IJ template was provided to the Administrator and ADON on 06/05/25 at 5:10 PM. While the IJ was removed on 06/06/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm to ensure the effectiveness of the training and plan of removal components. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse and neglect were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency in accordance with State law through established procedures for one, (Resident #1) of eight residents reviewed for resident neglect.<br><br>The facility failed to report a potential allegation of neglect to the Abuse Coordinator when RN A failed to provide care and treatment for Resident # 1, who was in her care assignment. LVN B and CNA C were aware that RN A did not provide care to Resident #1. RN A was allowed to work on 05/31/25 to 06/02/25 after she failed to provide care and treatment when Resident # 1 requested to go the hospital on [DATE]. Police notified EMS of Resident #1's request to go to the hospital for a possible blood clot on 05/31/25. RN A was suspended on 06/02/25 by the Abuse Coordinator.<br><br>An identification of an Immediate Jeopardy (IJ) on 06/05/25 at 5:10 PM. While the IJ was removed on 06/06/25 at 8:15 PM, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>These failures placed residents at risk for serious injuries, abuse, and serious harm.<br><br>Findings included:<br><br>Review of Resident #1's face sheet undated reflected Resident #1 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] from the hospital. Resident #1 had diagnoses of acute embolism and thrombosis of right femoral vein (presence of a blood clot in the femoral vein of the right leg), atrial fibrillation (irregular heartbeat), acute embolism and thrombosis of right lower extremity bilateral (presence of blood clots in the deep veins in both legs), chronic pulmonary edema (the buildup of fluid in your lungs), peripheral vascular disease (condition where blood vessels outside the heart and brain are affected, reducing blood flow to the limbs). Resident #1 was his own responsible party.<br><br>Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS of 15 indicating he was cognitively intact. Resident #1 required set up assistance to independent with ADLs.<br><br>Review of Resident #1's Comprehensive Care Plan reflected the following:<br><br>-dated 04/21/25 Resident will call [transportation] to go to the hospital wanting IV pain medication. Even when offering his pain medication he has on hand.<br><br>-dated 06/02/25 high probability of [deep vein thrombosis] to lower extremities. Refuses to take any type of anticoagulant. Intervention included to notify provider and send resident to ER when [complaint of shortness of breath].<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -dated 06/02/25 Risk for deep vein thrombosis. Interventions include evaluate legs for swelling and monitor legs for changes in skin color, temperature.<br><br>Review of Resident #1's Nurse progress note by RN A dated 05/31/25 reflected the following: [LVN D] notified this nurse that resident wanted to talk. when this nurse arrived at resident room. resident stated, I said to that other nurse that when I need to go he hospital . I need to go. this nurse said, alright you can go then, resident interrupted nurse and stated, you know what get out of here. now! get the hell out of here. this nurse said OKAY and stared walking down the hall. Resident followed this nurse down the hall and became aggressive and started yelling at this nurse, you f****** bitch I will destroy you. I will ruin you. f*** you. resident waving hands in the air. This nurse left and went to shelter in 300 unit, then police were called. nurse asked the police to speak to resident because of the potential for scalation and that, he might physically attack this nurse later. this nurse also asked the police to request resident to delete the videos on his phone that he have been recording of this nurse on the previous morning in the lobby area of this facility. resident left facility via EMS. nurse was not notified of this.<br><br>Review of local police call record dated 05/31/25 at 6:14 PM a call for a welfare check at the facility reflected patient is being aggressive towards staff with caller as the RN Nurse for night shift who is concerned for her safety. The caller reported patient verbally assaulted the caller. At 6:34 PM police arrived to the facility and 6:45 PM a request for EMS for patient transport possible blood clot. EMS notified. EMS transport one at 7:00 PM.<br><br>Review of Resident #1's EMS record dated 05/31/25 reflected Patient was noted to be sitting on the edge of the bed with the left leg swollen. Patient stated that he was having some sudden trouble breathing with leg pain as well. Patient stated that he has history of blood clots and that today it was getting worse. Patient states that it's gotten even more unbearable for the last 45 minutes when his shortness of breath started. Patient stated that he tried telling the nurse staff but they would not take him seriously. Patient then stated he got irritated and raise his voice at the staff and law enforcement was called .Medic 2 transported one patient code [emergent] to [hospital] without incident.<br><br>Review of Resident #1's hospital records reflected Resident #1 was admitted to the hospital on [DATE] from nursing home with a history of factor V Leiden deficiency (inherited disorder that increases the risk of developing blood clots) with a history of chronic bilateral lower extremity DVTs .who was brought to the [emergency department] from the nursing nurse via EMS with a chief complaint of worsening of his lower extremity edema with pain associated with worsening dyspnea over the last 2 days .He became concerned for new DVT probably [pulmonary embolism] because of his shortness of breath, requested EMS .In the [emergency department] venous dopplers currently ordered but are pending. CT angiogram of the chest revealed no pulmonary embolism .Labs include a CBC that revealed a mild normocytic anemia .Patient was initially on a heparin drip pending the venous doppler. He is being admitted for further management .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation and Interview on 06/03/25 at 9:59 AM with Social Worker revealed Resident #1 was in his room sitting on his bed. Resident #1 stated he wanted the social worker to stay in the room. Resident #1 stated on 05/31/25 he asked to speak to RN A. He stated RN A came to his room and he told her he needed to go to the hospital for shortness of breath and leg pain. Resident #1 stated RN A refused to send him to the hospital on [DATE] at the beginning of her shift and RN A did not care what happened to me. He stated he did get upset yelled at RN A. He stated the police were called to the facility by staff. He stated the police called EMS for him noticing he was short of breath. He stated the EMTs took me to the hospital for possible blood clot. He stated he was complaining of shortness of breath and leg pain. He stated on 05/31/25 he told CNA C about RN A refusing to send him to the hospital. He stated RN A would not even print off his face sheet so he could have it when EMTs transporting him to the hospital. He stated he tried to do the right thing by letting RN A know he needed to go to the hospital. He stated he returned back to the facility from the hospital yesterday on 06/02/25. He stated the Administrator was aware of the allegation and he was told by Administrator that RN A would not be returning back to the facility.<br><br>Interview on 06/03/25 at 10:35 AM with DON revealed she received a phone call on 05/31/25 from RN A about not wanting to take care of Resident #1 anymore because he was being verbally aggressive towards me and asked if LVN B could take care of him. DON stated she advised RN A to inform LVN B to take care of Resident #1 for the rest of the shift. DON stated it was not reported to her of Resident #1 wanting to go to the hospital. She stated at 6:38 pm she spoke to CNA C about RN A calling the police on Resident #1 but did not know why RN A called the police. DON stated she reached out to RN A who told her Resident #1 was being aggressive towards her and she was afraid of Resident #1. DON stated she was not notified about Resident #1 wanting to go to the hospital. She further stated she was not informed Resident #1 was sent to the hospital. She stated she should have been notified of Resident #1 being sent to the hospital. DON stated she did not find out Resident #1 had been sent to the hospital or in the hospital until 06/02/25 when she was at the facility. She stated she reached out to Resident #1 on 06/02/25 via telephone who reported to her about RN refusing to send him to the hospital on [DATE] when he reported having trouble breathing and needing to go to the hospital. She stated she immediately reported the neglect allegation to the Administrator. She stated Administrator reached out to RN A who was suspended pending investigation on 06/02/25.<br><br>Interviews on 06/03/25 at 1:11 PM with CNA C revealed on 05/31/25 Resident #1 was concerned about leg pain and swollen leg thought he might have a blood clot. She stated Resident #1 reported to her he wanted to be sent to hospital CNA C stated Resident #1 told her that he tried to do it their way by notifying RN A of needing to go to the hospital so they can send him to hospital but Resident #1 stated RN A blew him off. CNA C stated she did not have an opportunity to report Resident #1 wanting to be send to the hospital to LVN B because she got distracted when the police arrived to the facility. She stated she contacted the DON via telephone on 05/31/25 about police in the facility and RN A had called the police on Resident #1. CNA C stated Resident #1 was walking slowly and was flustered with RN A. She stated Resident #1 went back to his room and police contacted EMT to send him to the hospital. She stated she did not know if LVN B was aware of Resident #1 wanting to go to the hospital. CNA C stated Resident #1 had issues with RN A but RN A was still Resident #1's nurse. She stated RN A would ask LVN B to give Resident #1 his medications. She stated her last in-service on abuse/neglect was about a couple weeks ago to maybe a month ago. She stated she had not been in-serviced on 05/31/25 or after on abuse/neglect policy including reporting. She stated she had not spoke to Administrator or DON to give them a statement about the incident on 05/31/25 with Resident #1.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/04/25 at 8:09 PM with CNA C revealed she reported to the DON about RN A not sending Resident #1 to the hospital when she reported to DON about RN A calling the police on Resident #1. She stated she should have called the Administrator who is the abuse coordinator immediately to report the allegation of neglect of Resident #1 reporting RN A did not send him to the hospital. She stated she was verbally counseled for failure to report the allegation to the Administrator immediately yesterday. She stated RN A worked the rest of her shift on 05/31/25 and worked on 06/01/25 night shift until 6 AM on 06/02/25. She was knowledgeable of different types of abuse/neglect policy and reporting requirements and was in-serviced yesterday.<br><br>Interview on 06/03/25 at 2:52 PM with Social Worker revealed Resident #1 reported on 05/31/25 to RN A he was short of breath and was concerned about a possible blood clot. She was not aware of RN A refusing to send him to the hospital until 06/03/25. Social Worker stated RN A had an attitude problem and Resident #1 reported to her RN A was mouthy to him.<br><br>Interview on 06/04/25 at 11:05 AM with Police Officer H revealed the police officer who was dispatched to the facility on [DATE] worked the night shift. He stated he would leave a message to call surveyor. He stated based on his review of the report it reflected on 05/31/25 a nurse from the facility called to report Resident #1 having a verbal altercation with nurse. He reviewed the call details report reflecting Resident #1 complained of leg pain when police arrived at the facility and police notified EMTs to send Resident #1 to the hospital.<br><br>Interview on 06/04/25 at 8:36 PM with CNA E revealed on 05/31/25 she did not know why Resident #1 was being sent to the hospital but saw him on the EMS stretcher. She stated the Administrator is the abuse coordinator. She stated RN A could be condescending and act like she is better than anyone else.<br><br>Interview on 06/04/25 at 8:44 PM with LVN D revealed she had been administering Resident #1's medications to Resident #1 when RN A was assigned as his nurse for the last couple of weeks. She stated RN A told her that she could not administer medications to Resident #1 and DON was aware of it. She stated she did not follow up with DON or the Administrator about RN A not administering Resident #1's medications on her shifts and requesting her to give Resident #1 his medications. She stated she was not asked to be Resident #1's charge nurse on 05/31/25. She stated the police officer asked her to print off Resident #1's face sheet but did not understand why RN A was not more involved in Resident #1 being sent to the hospital. She stated she did not know why Resident #1 was sent to the hospital. She stated she did not make any notifications of Resident #1 going to the hospital since he was RN A's resident on 05/31/25. She stated she heard Resident #1 cussing right after shift change but she did not really think anything of it since it stopped. She stated Resident #1 did verbally cuss out staff. She stated as the charge nurse if a resident reports to her wanting to go to the hospital, she would assess, find out more information about what was going on with resident and take vitals. She stated residents have a right to go to the hospital if he or she wants to. She stated she would contact the physician to report her assessment of the resident and what was going on with resident. She stated if a resident wants to go to the hospital she would report it to physician and DON.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/05/25 at 9:14 AM with DON revealed RN A called the police on Resident #1. She stated RN A told her Resident #1 was cussing and yelling at her. DON stated RN A told her she was in fear for her life so this is why she called the police. DON stated she expected the nurse to assess resident including head to toe, vital, and asking to find out more about resident's change of condition. She stated RN A should have notified the physician and if resident wanted to be sent out to the hospital to send resident out to the hospital. She stated Resident #1 was his own responsible party. She stated if she had known on 05/31/25 of RN A refusing to send Resident #1 to the hospital she would have reported an allegation of abuse/neglect to the Administrator immediately. She stated prior to this incident there had been customer service complaints of RN A's tone being rude. She stated Resident #1 did not like her. She was not aware of RN A not giving Resident #1 her medications when she was his charge nurse and having other nurses administer his medications. She stated Resident #1 was admitted to the hospital on [DATE]. She stated Resident #1 had a history of DVT in a previous hospitalization.<br><br>Interview on 06/05/25 at 9:33 AM with Resident #1's MD revealed he could not recall if he was notified about Resident #1 being sent to the hospital on [DATE]. He stated he expected the nurse to assess the resident including taking vitals and listening to lungs. He expected the nurse to find out more information of why Resident #1 wanted to be sent to the hospital. Resident #1's MD stated should call the on-call physician to notify of Resident #1 symptoms and change of condition. He stated Resident #1 had a history of calling Uber to go to hospital. He stated if resident wanted to go to the hospital, the nurse will contact EMS for transportation. He stated the risk to the resident could be potential risk of pulmonary embolism or heart attack.<br><br>Interview on 06/05/25 at 10:17 AM with LVN D revealed Resident #1 told her he needed to talk to RN A but did not tell him what was going on. She reported to RN A at shift change which was 6:00 PM on 05/31/25 that Resident #1 wanted to talk to him. LVN D stated she was not informed Resident #1 wanted to go to the hospital and was not aware of any change of condition.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/07/25 at 11:18 AM with RN A revealed LVN D reported to her Resident #1 wanted him to go see him at beginning of her shift at 6 PM. She stated she found it odd he wanted to talk to her because she stated she stayed out of his room, she did not like to deal with him and if he walking down the hall I go the other way. She stated when she entered Resident #1's room. RN A stated he told he needed to go to the hospital and she told him you can go. RN A stated Resident #1 started yelling at her, told her to get the hell out of his room. She stated she left his room and he followed her down the hall saying who the hell are you, I am going to destroy you. RN A stated she did not know what Resident #1 was complaining of and did not have a chance to ask any questions. She stated she did not have a chance to assess him or ask him more questions to find out what he wanted to go to the hospital. LVN D stated she went to shelter on the secure unit and called the police to inform of Resident #1's aggression towards her. She stated she needed to administer her medications to the residents on his hall and was afraid he might attack me so she called the police. RN A stated she called the police after she sheltered on the secure unit and it took like 20 to 30 minutes for them to arrive. She stated she did not inform the police about Resident #1 wanting to go to the hospital. She did not inform anyone about Resident #1 wanting to go to the hospital. She stated the police called for Resident #1 to be sent out to the hospital. She stated she had 2 incidents with Resident #1 when giving him his medications prior to 05/31/25 and Resident #1 got upset at her for opening the door and waking him up for his medications. She stated Resident #1 followed her and yelled at her by cussing her out. She stated she gave the other nurse on her shift to have the other nurse administer his medications. She stated she would follow-up with other nurse to see if it was given and documented it was given. She stated the DON called me on 05/31/25 to find out why I called the police. She stated she did not inform anyone about Resident #1 going to the hospital. She stated Resident #1 did have chronic DVT history. She stated when she was contacted by the facility on 06/02/25 she told them she quit because she knew Resident #1 would back at the facility.<br><br>Interview on 06/05/25 at 12:10 PM with Administrator revealed Resident #1 did have past issues with nurses about wanting to get medications on time. He stated Resident #1 did have history of being verbally aggressive to staff. DON reported to him on 06/02/25 of Resident #1 reporting RN A refused to send him to the hospital and police had to call EMS to send him to the hospital. The Administrator stated this was an allegation of neglect and possibly abuse so he reported it to HHSC. He stated he initiated the investigation and contacted RN A to suspend her pending investigation. He stated RN A refused to give a witness statement for the incident on 05/31/25 and RN told him Fuck this facility and Fuck those residents. He stated he was not aware of RN A not giving Resident #1 his medications on her shift as the charge nurse and having the other nurse give the medications to Resident #1. He stated CNA C should have immediately notified me as the abuse coordinator on 05/31/25 of RN A refusing to send Resident #1 to the hospital. He stated RN A should have assessed Resident #1 and/or tell other nurse about Resident #1 wanting to go to hospital. He stated the failure to immediately report abuse or neglect to me could place residents at risk for resident abuse/neglect to continue and not be aware of abuse/neglect. He stated this placed the residents at risk for further abuse and neglect with allowing RN A to continue to work and could possibly do it to someone else.<br><br>Interview on 06/05/25 at 7:14 PM with Local Police Officer G revealed he did come out to the facility on [DATE]. He stated based on interviews with facility staff it seemed like Resident #1 did not seem to get along with RN A. He stated Resident #1 requested to the police to go to the hospital on [DATE] per a possible blood clot. He stated he called EMS and Resident #1 was sent out to the hospital.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of RN A's timecard for 05/31/25 reflected RN A worked from 05/31/25 at 5:43 PM to 6:14 AM on 06/01/25. On 06/01/25 at 5:43 PM to 6:21 PM on 06/02/25.<br><br>Review of facility's policy last revised September 2022 Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating reflected All reports of resident abuse (including injuries of unknown origin, neglect, exploitation or theft/misappropriation of property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management .Reporting allegations to the Administrator and Authorities 1. If resident abuse, neglect .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines . 6. Upon receiving any allegations of abuse, neglect .the administrator is responsible for ensuring what actions (if any) are needed for the protection of residents .12. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete .<br><br>On 06/05/25 at 5:10 PM, the Administrator and ADON were informed in person with DON and Regional VP on the phone of an IJ situation. The Administrator was provided the IJ template at this time.<br><br>The facility's plan of removal was accepted on 06/06/25 at 10:44 AM. Review of facility's Plan of Removal for F609 reflected the following:<br><br>The facility failed to report a potential allegation of neglect to the Abuse Coordinator when RN A failed to provide care and treatment for Resident #1, who was in her care assignment.<br><br>The facility medical director was notified of the Immediate Jeopardy by the Facility Administrator on 06/05/2025.<br><br>Resident #1 was sent to the ER for evaluation and treatment on 5/31/25 and returned to the facility on [DATE].<br><br>RN A was suspended on 06/02/2025 by the DON and Administrator and terminated from her position at the facility on 06/03/2025 by the DON and Facility Administrator/Abuse Coordinator.<br><br>LVN B and CNA C were in-serviced by the DON and Administrator on 6/3/25 regarding immediately reporting potential Abuse, Neglect, and Misappropriation. Both employees were given written disciplinary action related to not reporting immediately, by the DON on 06/04/2025.<br><br>All staff were in-serviced by ADON/DON on Abuse, Neglect, and Exploitation, and reporting Abuse and Neglect to the abuse coordinator/facility administrator immediately, beginning on June 2nd 2025 and were completed on 06/05/2025. ADMIN or designee will monitor and be responsible moving forward. In-services were completed per the Director of Nursing. Any new staff or agency staff will be in-serviced by the DON on Abuse, Neglect, and Exploitation policy before the start of their first shift.<br><br>DON and Administrator will interview 3 staff daily related to their understanding of the in-service education provided, for the next 4 weeks.<br><br>Admin and ADON conducted safe surveys with alert residents on 6/3/25.<br><br>Review of the IJ monitoring for the facility's plan of removal reflected the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interviews from 06/06/25 at 2:25 PM to 7:40 PM with four nurses from different shifts (LVN I, RN O, LVN Q and Agency LVN S) they had been in-serviced on abuse/neglect policy,. All were knowledgeable of types of abuse/neglect and would report any allegations immediately to Administrator who was the abuse coordinator once the resident was safe.<br><br>Interviews from 06/06/25 at 2:42 PM to 7:20 PM with eight CNAs from different shifts (CNA J, CNA K, CNA L, CNA M, CNA N, CNA P, CNA R, and CNA T) revealed they had been in-serviced on abuse/neglect policy, . All were knowledgeable of types of abuse/neglect and would report any allegations immediately to Administrator who was the abuse coordinator once the resident was safe. They were all knowledgeable of where to find contact information for the abuse coordinator.<br><br>Interviews from 06/06/25 at 3:40 PM to 7:26 PM with three facility staff (Activity Director, Dietary [NAME] U and Dietary Aide V) reflected they were in-serviced on abuse/neglect, reporting requirements of allegations and resident rights. All three staff were knowledgeable of types of abuse/neglect and would report any allegations immediately to Administrator who is the abuse coordinator once the resident was safe. They were aware of resident rights including resident right to go to the hospital. They stated they would notify the DON and Administrator if resident rights were violated. They were all knowledgeable of where to find contact information for the abuse coordinator.<br><br>Interview on 06/06/25 at 3:53 PM with Administrator revealed staff have been in-serviced from different shifts on abuse/neglect policy and reporting requirements. He stated all staff who have been in-serviced should be aware to notify him immediately of any allegations of abuse/neglect. He stated CNA C and LVN B have been in-serviced on abuse/neglect and reporting requirements to immediately report any allegations to him. He stated any staff who have not been in-serviced will be unable to work until in-serviced.<br><br>Interview on 06/06/25 at 4:41 PM with ADON revealed staff had been in-serviced on abuse/neglect. She was knowledgeable of types of abuse/neglect and would report any allegations to Administrator immediately once the resident was safe. She stated LVN B had been in-serviced but she was unavailable to contact due to being on personal leave at this time. She stated LVN B would be in-serviced in person again to ensure her understanding of all the in-services when she returns back to work from her leave.<br><br>Review of In-services for Abuse/Neglect dated 06/02/25 to 06/05/25 reflected staff were in-serviced on abuse/neglect policy and reporting requirements including CNA C and LVN B.<br><br>Review of 2 of 2 resident clinical records (Resident #2 and #3) revealed no concerns with abuse or neglect.<br><br>Review revealed CNA C and LVN B were verbally counseled for not reporting an allegation of abuse/neglect signed by employees on 06/04/25.<br><br>Review of Reporting of Abuse and Neglect dated 06/05/25 reflected if you feel, see or even think abuse or neglect is happening, immediately do the following: Get the resident or residents to safety. Immediately call the abuse coordinator [Administrator] with phone number provided.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675067 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gainesville Convalescent Center | 1900 O'Neal St<br>Gainesville, TX 76240 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An IJ was identified on 06/05/25. The IJ template was provided to the Administrator and ADON on 06/05/25 at 5:10 PM. While the IJ was removed on 06/06/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm to ensure the effectiveness of the training and plan of removal components. |