STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675067	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely for 2 of 6 residents (Resident #3 and Resident #4) reviewed for resident rights: The facility failed to provide clean bed linens for Resident #1 and Resident #2's bed on 2/17/26. This failure could place residents at risk of exposure to infectious diseases and other unsanitary health hazards.Record review of Resident #3's face sheet dated 2/17/26 reflected she was a [AGE] year-old female with an original admission date of 5/31/25 and a readmission date of 9/28/25. Resident #3 had the following active diagnoses: muscle wasting and atrophy (decrease size, mass and strength of muscle tissue), muscle weakness, need for assistance with personal care, and Depression (a medical illness characterized by a persistent, intense, and long-lasting low mood, loss of interest and decreased energy). Record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected Resident #3 had moderate cognition and a BIMS of 10. She had limitations for upper and lower extremities on both sides. Resident #3 was noted to be incontinent of bowel and bladder. During an observation of Resident #3's bed on 2/17/26 at 9:59am AM reflected sheets and a washable incontinent pad on the bed. The incontinent pad had a yellow stain on the lower right side of it about 4 inches long and 3 inches wide in an oval shape. An interview and observation of Resident #3's bed with CNA A on 2/17/26 at 10:06 am revealed she did not recall when she last changed Resident #3's sheets and incontinent pad. CNA A noted the stain on the pad and stated she had gotten Resident #3 up and ready but hadn't had a chance to change her sheets. She immediately took all the sheets off the bed, including the incontinent pad and removed them from the room. She stated the risk to the residents of not changing their sheets when dirty would be the spread of infection. Record review of Resident #4's face sheet dated 2/17/26 reflected he was a [AGE] year-old male with an original admission date of 3/10/23 and a readmission date of 9/25/25. Resident #4 had the following active diagnoses: Huntington's Disease (a fatal neurodegenerative disorder that causes progressive breakdown of nerve cells in the brain), need for assistance with personal care, urinary tract infections and post-traumatic stress disorder (mental health disorder that is characterized by flashbacks, nightmares and severe anxiety from past traumatic events experienced). Record review of Resident #4's Comprehensive MDS assessment dated [DATE] reflected Resident #4 had severe deficits in cognition and a BIMS score of 7. He had limitations to his upper extremities on both sides. Resident #4 needed substantial assistance with toileting and was occasionally incontinent of bladder. An observation of Resident #4's bed on 2/17/26 at 10:03 am reflected sheets and a washable incontinent pad was on the resident's bed. The incontinent pad had two small red circles on the right side. An interview and observation of Resident #4's bed with CNA A on 2/17/26 at 10:06 am revealed she last changed Resident #4's bed sheets on 2/16/26. She stated the stain on his (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent pad looked like blood and immediately stated she could change it at that time. CNA A stated she typically changed the incontinent pads when she saw they were dirty but had not noticed Resident #4's was dirty. An interview with LVN C on 2/17/26 at 10:25 am revealed she had not been in Resident #4's room since she started her shift at 6 am because Resident #4 had been in the living room the whole time, and she had not checked her bed linens. She also stated she had not assisted Resident #4 to her room and therefore had not seen the linens on her bed. LVN C stated when she noticed beds were soiled, she would let the patient know that she had gotten someone to assist to change the linens. LVN C stated residents' bed linens should have been changed any time there was anything on them. An interview with CNA B on 2/17/26 at 12:42 pm revealed bed linens should be changed every shower days or as needed when visibly soiled. CNA B described visibly soiled as any sign of dirt, stains, or bodily fluids on the sheets. An interview with the ADON on 2/17/26 at 2:34 pm revealed the expectations for bed linen changes were they should have been changed on shower days and as requested.The ADON stated the incontinent care pads should have been changed with every incontinent care episode. The residents were at risk of skin breakdown if they had dirty sheets. An interview with the DON on 2/17/26 at 3:00 pm revealed she did not know what was on the incontinent pad for Resident #3 but believed the red stuff on Resident #4's pad was his red juice because Resident #4 had poor muscle control and sometimes spilled his drinks from his cup. The DON stated the expectation on bed linens was they should be changed when visibly soiled and on shower days. The DON stated soiled bed linens could have affected the residents' dignity and how they felt at the facility. The DON stated the residents should have had a clean home. An interview with the Administrator on 2/17/26 at 3:36 pm revealed the expectation at the facility was residents should have been provided with a clean home environment. It was the responsibility of the CNAs to ensure residents' bed linens were always clean. The Administrator stated the risk to the residents of not having clean bed linens was issues with infection control. Requested the facility's policy on cleanliness of the facility related to bed linens and was informed by the Administrator, on 2/17/26 at 3:07 pm, they did not have a policy for bed linens or cleanliness of the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 2 of 6 residents (Resident #1 and Resident #2) reviewed for care plans. 1. The facility failed to ensure Resident #1's comprehensive care plan was complete and reflected his need for a therapeutic diet. 2. The facility failed to ensure Resident #2's comprehensive care plan was complete and reflected her need for a therapeutic diet. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. Record review of Resident #1's face sheet dated 2/17/26 reflected he was a [AGE] year-old male with an admission date of 1/9/26. Resident #1 had the following active diagnoses: muscle wasting and atrophy (decrease size, mass and strength of muscle tissue), Hypothyroidism (endocrine disorder where the thyroid fails to produce sufficient thyroid hormones), Hypotension (abnormally low blood pressure) and Type 2 Diabetes (a metabolic disorder characterized by high blood sugar levels). Record review of Resident #1's Initial MDS assessment dated [DATE] reflected Resident #1's cognition was intact, and he had a BIMS of 14. Section K noted a therapeutic diet on admission and while a resident. Record review of Resident #1's Baseline Care Plan dated 1/9/26 reflected regular with thin liquids diet. Record review of Resident #1's Comprehensive Care Plan Report date 1/21/26 reflected a one page report with only one completed care area related to his code status. The document did not reflect a care area related to his need for a therapeutic diet.Record review of Resident #2's Initial MDS Assessment date 2/4/26 reflected she was a [AGE] year-old female with an admission date of 1/30/26. Resident #2 had the following active diagnoses: Hypertension (high blood pressure), Renal Failure (occurs when kidneys lose the ability to effectively filter waste products, toxin and excess fluid from blood), Diabetes Mellitus (a metabolic disorder characterized by high blood sugar levels) and Irritable Bowel Syndrome (chronic functional disorder of the gastrointestinal tract characterized by recurrent abdominal pain, discomfort and changes in bowel habit). Resident #2's cognition was intact with a BIMS of 15. Section K noted a therapeutic diet while a resident.Record review of Resident #2's Order Summary Report dated 2/17/26 reflected resident had an order for Controlled Carbohydrate Diet with a start date of 1/30/26.Record review of Resident #2's Baseline Care Plan dated 1/30/26 reflected a regular diet with thin liquids. Record review of Resident #2's Comprehensive Care Plan Report date 1/21/26 reflected a one-page report with only one completed care area related to her code status. The document did not reflect a care area related to her need for a therapeutic diet.An interview with the MDS Nurse Coordinator on 2/17/26 at 2:25pm revealed she was responsible for the completion of all residents' comprehensive care plans. The MDS Nurse Coordinator stated when she completed the residents' MDS assessments, she had one to two weeks to complete their care plan. The MDS Nurse Coordinator stated Resident #1 and Resident #2's care plans were incomplete. She stated she had two weeks from the time she completed the residents' MDS assessments. She stated she was not sure if that was the policy of the facility. She stated she was working on Resident #2's Care Plan that day. She stated she was behind on completing care plans for new admission residents and Resident #2's Care Plan was due by 2/18/26. She stated Resident #1's Care Plan was due 1/29/26. She stated Care Plans listed the residents' needs and how they were being addressed. She stated therapeutic diets would have been listed on a care plan. She stated the only risk to the residents of not having a complete Care Plan was if the Care Plan was used by the nurses to determine the type of care the residents needed, but she stated most nurses referred to the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chart for the residents' needs; not their care plan. An interview with the DON on 2/17/26 at 3:10 pm revealed all residents should have a complete comprehensive care plan. The DON stated the Care Plans should have included important things like therapeutic diets, therapies, behaviors, resident refusals to name a few. She stated the care plan should provide a comprehensive plan for the residents' care. An interview with the Administrator on 2/17/26 at 3:39 pm revealed he was aware the MDS Nurse Coordinator was behind on the completion of resident care plans. The Administrator stated they had identified the Care Plans as an issue and was one of the systematic changes in their QAPI meeting. The Administrator stated they were going to have the MDS Nurse Coordinator update and complete Care Plans during their stand up meetings daily. The Administrator stated the risk to the resident of not having had a completed care plan was the residents' needs may not have been met timely. Record review of the facility's policy Care Planning-Interdisciplinary Team revised December 2024 reflected .The interdisciplinary team is for the development of resident care plans.1.Resident care plans are developed according to the timeframes and criteria established by S483.21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to assist residents who were unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 6 residents (Resident #3) reviewed for quality of life. The facility failed to groom Resident #3's facial hair on 2/17/26.The facility failed to assist Resident #3 with showers on 2/3/26 and 2/14/26. These failures could place residents at risk of exposure to infectious diseases, and affect their dignity.Record review of Resident #3's face sheet dated 2/17/26 reflected she was a [AGE] year-old female with an original admission date of 5/31/25 and a readmission date of 9/28/25. Resident #3 had the following active diagnoses: muscle wasting and atrophy (decrease size, mass and strength of muscle tissue), muscle weakness, need for assistance with personal care, and Depression (a medical illness characterized by a persistent, intense, and long-lasting low mood, loss of interest and decreased energy). Record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected Resident #3 had moderate cognition and a BIMS of 10. She had upper and lower limitations of her extremities on both sides. Resident #3 required partial/moderate assistance for showers, baths, transfers, and supervision for personal hygiene to include shaving. Record review of Resident #3's shower sheets dated February 1, 2026 to February 17, 2026 reflected Resident #3 received showers on 2/5/26, 2/9/26, and 2/12/26. She refused one shower on 2/7/26. There were no shower sheets for her scheduled shower days on 2/3/26 and 2/14/26 , or any other day. Observation and interview of Resident #3 on 2/17/26 at 10:32 am revealed she was wearing clothing that was stained and dirty. It was noted Resident #3 had facial hair on her chin that was significantly visible. Resident #3 stated she frequently asked staff to shave her facial hair, but they frequently ignored her request. Resident #3 could not recall the last time she had gotten her chin hair shaved. Resident #3 stated it had been a while since they had shaved her ,and she recalled it was during a shower. Resident #3 stated she also had not gotten a shower in a long time. She stated she had gone days without showering, despite asking for a shower. An interview with CNA A on 2/17/26 at 10:06 am revealed she could not recall when she last bathed or shaved Resident #3. She acknowledged Resident #3 had visible facial hair, and she stated she was scheduled to bathe her today. CNA A stated she shaved Resident #3 before, but not recently. CNA A stated Resident #3's shower days were Tuesday, Thursday and Saturday. She did not recall whether she bathed her on Tuesday or Thursday of last week because the night shift may have bathed her. CNA A denied Resident #3 had ever requested to be shaved outside of her shower days. CNA A stated having facial hair as a female would have made her insecure and affected her dignity.An interview with CNA B on 2/17/26 at 12:42pm revealed when a resident refused a shower, she would offer it to the resident at least 3 times throughout her shift and then notified the nurse of the refusal. CNA B stated they were required to groom both male and females every shower, unless the resident refused it. An interview with the ADON on 2/17/26 2:34 pm revealed Resident #3 would, at times ,refuse to allow her facial hair to be cut. The ADON stated she did not know when she was last shaved or whether she had refused grooming recently. The ADON stated the expectation for staff would be to cut female residents' facial hair daily because women should not have facial hair. The ADON stated at minimum residents should have gotten shaven on their shower days and upon request or when facial hair was visible. It would affect residents' dignity when they have facial hair. The ADON stated Resident #3 had 3 showers since February 1, 2026, 1 shower she refused and could not state the reason the other two showers had not occurred. She stated they had no documentation Resident #3 had refused showers on 2/3/26 or 2/14/26. The ADON stated the risk to the resident of irregular showers could (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been issues with residents' dignity, risk of infection, and skin breakdown.An interview with the DON on 2/17/26 at 3:00 pm revealed she had not noticed Resident #3's facial hair. She stated she was aware the resident would refuse care at times, but could not say definitively it was the reason she had facial hair. The DON stated showers, and shaving should be done 3 times per week or upon request. She stated if a resident refused, CNAs were supposed to ask residents if they wanted a bath on 3 separate occasions, if they still refused, then the CNAs would have told the nurse so she could encourage the residents to bathe and if they still refused, they would document the refusal. The DON stated facial hair of residents should be cut every shower day or as requested by the residents. An interview with the Administrator on 2/17/26 at 3:36pm revealed it was the responsibility of CNAs to shower and shave residents. The Administrator stated female resident should be showered on their shower days and if they had facial hair, they should have been shaven on their shower days. The Administrator stated it could affect a female resident's dignity if she had facial hair and wanted it removed. Record review of the facility's policy Activities of Daily Living (ADL), Supporting revised on February 2025 reflected . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care); .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs for 2 of 6 residents (Resident #1 and Resident #2) reviewed therapeutic diets: The facility failed to provide Resident #1 with food that was consistent with his prescribed fortified food plan diet on 2/17/26.The facility failed to provide Resident #2 with food that was consistent with her prescribed Low Concentrated Sugar diet on 2/9/26 and 2/10/26. These failures could place residents at risk of declining health and significant fluctuations with their weight.Record review of Resident #1's face sheet dated 2/17/26 reflected he was a [AGE] year-old male with an admission date of 1/9/26. Resident #1 had the following active diagnoses: muscle wasting and atrophy (decrease size, mass and strength of muscle tissue), Hypothyroidism (endocrine disorder where the thyroid fails to produce sufficient thyroid hormones), Hypotension (abnormally low blood pressure) and Type 2 Diabetes (a metabolic disorder characterized by high blood sugar levels). Record review of Resident #1's Initial MDS assessment dated [DATE] reflected Resident #1's cognition was intact, and he had a BIMS score of 14. Section K noted a therapeutic diet on admission and while a resident. Record review of Resident #1's Order Summary Report dated 2/1/26 reflected resident had an order for Fortified Food Plan Diet Regular Texture, Regular Liquids consistency with a start date of 1/23/26. Record review of Resident #1's Breakfast Ticket dated 2/16/26 reflected .Diet: Low Concentrated Sugar/Consistent or Controlled Carbohydrates. An observation and interview with Resident #1's in his room on 2/17/26 at 9:52am reflected an untouched tray of food that contained 1 sausage, 1 square egglike substance, a cup of oatmeal, 1 French toast, maple syrup, and a red juice. On the tray was the breakfast ticket reflected resident received a Low Concentrated Sugar/Consistent or Controlled Carbohydrate tray. Resident #1 stated he had not eaten any of his breakfast because he had no appetite. An interview with the Dietary Manager on 2/17/26 at 1:14pm revealed she did not recall the diet Resident #1 was prescribed. She checked her records and stated she had been providing Resident #1 an Low Concentrated Sugar diet, but just noticed the physician had changed Resident #1's diet to Fortified Food Plan which required the resident being offered bigger portions and more food equaling more calories. She stated the Low Concentrated Sugars was essentially smaller portions equaling lesser calories. She stated she did not recall receiving notification of diet change from the nurses or the dietician. She stated the risk to the residents of not having gotten the proper diet was possible weight loss. Record review of Resident #2's Initial MDS Assessment date 2/4/26 reflected she was a [AGE] year-old female with an admission date of 1/30/26. Resident #2 had the following active diagnoses: Hypertension (high blood pressure), Renal Failure (occurs when kidneys lose the ability to effectively filter waste products, toxin and excess fluid from blood), Diabetes Mellitus (a metabolic disorder characterized by high blood sugar levels) and Irritable Bowel Syndrome (chronic functional disorder of the gastrointestinal tract characterized by recurrent abdominal pain, discomfort and changes in bowel habit). Resident #2's cognition was intact with a BIMS score of 15. Section K noted a therapeutic diet while a resident. Record review of Resident #2's Order Summary Report dated 2/17/26 reflected resident had an order for Controlled Carbohydrate Diet with a start date of 1/30/26. Record review of Resident #2's Lunch ticket dated 2/9/26 reflected .Regular Diet. Record review of Resident #2's Lunch ticket dated 2/10/26 reflected .Regular Diet. An interview and observation with Resident #2 in her room on 2/17/26 at 12:06 pm revealed she had gotten a regular diet and not a diabetic diet. She stated she had gotten regular portions of carbohydrates. She also had gotten regular sugar and desserts. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She showed the surveyor the meal tickets she saved in her drawer, and they were dated 2/9/26 and 2/10/26. She stated the tickets said, Regular Diet. At 12:45pm Resident #2 received her lunch food tray and the tray had her lunch ticket which reflected .Low Concentrated Sugar/Controlled Carbohydrate Diet. She stated it was the first time she had received a ticket labeled with that diet. She stated she had spoken to the Dietary Manager that morning and she told them she had not been receiving a diabetic diet. Observation of the food on her tray reflected a smaller portion of mashed potatoes, green beans, a dinner roll, meatloaf, Jello, tea and two packets of sweetener. An interview with the Dietary Manager on 2/17/26 at 1:14pm revealed she met with Resident #2 in the morning and the resident had told her she was diabetic. The Dietary Manager stated Resident #2 was on Regular Low Concentrated Sugar Diet and had been on it since she was admitted . She stated when a ticket reflected regular for the diet section it means there were no restrictions to their diet. She stated when a resident was Diabetic, they were given a Low Concentrated Sugar Diet and not a Regular diet. She stated if Resident #2 had received tray tickets that displayed Regular then Resident #2 got regular meals with no restrictions. The Dietary Manager stated Resident #2's order reflected she was prescribed a Low Concentrated Sugar diet. She was unsure of the reason Resident #2 had been receiving regular diet meals. The Dietary Manager stated Resident #2 told her she had not wanted to cut out any sweets. The Dietary Manager stated she followed the physician orders or dietician orders to determine which diet was provided to residents. She stated, at admission, she was provided a Low Concentrated Sugar Diet, but Resident #2 had not gotten it until that day. The risk to the residents of receiving a regular diet was she could have been consuming more sugar than she should which could affect her Diabetes. An interview with the ADON on 2/17/26 at 2:44 pm revealed the speech therapist, dietician, or physician could write a diet order. The orders should have been given to the Dietary Manager, as soon as they were changed. An interview the DON on 2/17/26 at 3:10 pm revealed it was the responsibility of the Dietician to notify the Dietary Manager of changes in therapeutic diets. She stated she believed the reason Resident #1's diet was not changed timely was because the Dietician was new and she had erroneously sent an incomplete spreadsheet of residents on therapeutic diets to the Dietary Manager. The DON stated she was unsure of why Resident #2 had gotten a regular diet instead of the Low Concentrated Sugar diet. She stated there was little to no risk for Resident #2 of having gotten a regular diet because there was not a big difference between a regular diet and Low Concentrated Sweet Diet. The risk for Resident #3 having gotten the wrong diet was it could increase weight loss. An interview with the Administrator on 2/17/26 at 3:39 pm revealed he believed the error with the diets for Resident #1 and Resident #2 was the Dietician changing diets without their knowledge resulted in an oversight of the changed diets for the two residents. The Administrator stated the risk to the residents of having been served the wrong diet would depend on the resident and the reason the diet was prescribed, but it could affect their health. Record review of the facility's policy Therapeutic Diets revised 10/2017 reflected .Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. 2. A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law. 3. Diet order should match the terminology used by the food and nutrition services department. 4. A 'therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: a. diabetic/calorie-controlled diet, b. low sodium diet; c. cardiac diet; and d. altered consistency diet.