

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Pine Tree Lodge Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2711 Pine Tree Rd Longview, TX 75604	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596</p> <p>Based on interview and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 5 residents reviewed for resident rights. (Resident #1)</p> <p>The facility failed to ensure staff assisted Resident #1 when answering his call light by turning his call light off and not returning to provide assistance.</p> <p>This failure could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety.</p> <p>Findings included:</p> <p>Record review of an undated face sheet indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of quadriplegia (the paralysis of both arms and legs due to various conditions, such as spinal cord injury, stroke, or cerebral palsy), anxiety, and seizures (uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness).</p> <p>Record review of the significant change MDS assessment dated [DATE] revealed Resident #1 had a BIMS of 14, which indicated his cognition was intact. Resident #1 required set up assistance for eating and oral hygiene and was dependent for staff for bed mobility and transfers.</p> <p>Record review of a care plan dated 09/12/2022 titled ADL assistance indicated Resident #1 had an ADL self-deficit related to quadriplegia. The intervention for Resident #1 revealed the staff was to encourage the resident to use his call light for assistance with ADLs.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/29/2024 at 1:00 p.m., Resident #1 stated he had a concern with the number of times the staff will come into the room and turn his call light off and tell him they would return and not return. He stated it happens nearly daily but had started to be a routine around the 1st of the year and he had made a grievance with the Administrator about these occurrences. He stated the CNA that did it daily quit working at the facility a few months back, but there was still CNAs that turned his light off and did not return. He stated he gave them time once they turned his light off before he turned it back on, but often they would come back in and turn it off again and walk out. He stated he would need anything from ice to be turned or a light turned on or off and they would not return to help him. He stated it made him feel angry and disrespected when his light was turned off and he had to wait on a different person to assist him with his needs.</p> <p>During a record review of a grievance dated 01/21/2024 it was noted that Resident #1 complained to the Administrator that around 3:00 a.m., he turned his call light on to be turned, get some ice water, and have his colostomy bag changed. He stated CNA B came into his room, asked him what he needed, turned the light off and said she would be back in a little while. The grievance revealed CNA B was interviewed by the Administrator and agreed she had turned the call light off without helping the resident and did not return to the resident's room before leaving the facility at the end of her shift around 6:00 a.m.</p> <p>During an interview on 07/31/2024 at 10:00 a.m., CNA B stated she remembered the incident in which she turned Resident #1's light off without helping him. She stated she had not turned his light off and not returned often, but it was difficult sometimes to find another CNA to assist with his care. She stated she never asked any of the nurses to assist her with Resident #1 because they were busy with their own work. She stated she was disciplined by the Administrator for leaving Resident #1's room without providing care. She stated not providing care for Resident #1 only occurred once or twice that she could recall.</p> <p>During an interview on 07/31/2024 at 11:15 a.m., LVN A stated she remembered CNA B leaving Resident #1 without providing care and assistance before leaving for the day. She stated she remembered because the Administrator questioned her about it and asked her why she had not helped with his care. She stated she was never made aware by CNA B that she needed assistance with Resident #1. She stated Resident #1 was a difficult resident that was very time consuming to assist. She stated she ended up answering his call light around 6:00 a.m. and attended to all his needs at that time but he was upset and stated he was tired of people turning his light off and leaving him unattended.</p> <p>During an interview on 07/31/2024 at 3:00 p.m., the Administrator was not aware of the details of the incident in which CNA B left Resident #1 without attending to his needs. She stated she was not the administrator at the time this occurred. She stated it was the responsibility of the staff to answer the call lights and to attend to the resident as quickly as they can. She stated the staff was to keep the call light on until the needs of the resident were met. The Administrator stated it was the responsibility of the DON and Administrator to ensure the needs of the residents were met by the staff assigned to care for them. She stated this was monitored by morning rounds and the grievance process.</p> <p>Review of an undated Resident Rights facility policy indicated, .Employees shall treat all resident with kindness, respect, and dignity .Federal and state laws guarantee certain basic right to all resident in this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness, and dignity .</p>		