

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/25/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #1) and 4 of 4 staff (CNA D, LVN C, LVN B, ADON) reviewed for infection control. The facility failed to ensure CNA D wore gloves carrying a soiled brief in the hallway on 6/24/2026. The facility failed to ensure LVN C washed hands prior to care, placed gloves on while walking to Resident #1's room, and wore proper PPE while transferring Resident #1 on/off toilet on 6/24/2026. The facility failed to ensure ADON wore proper PPE while assisting Resident #1 with transfer on/off toilet on 6/24/2026. The facility failed to ensure LVN B wore a gown and gloves during an observation of Resident #1's skin assessment. These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: Record review of Resident #1's face sheet dated 6/24/2026 indicated Resident #1 was a [AGE] year-old, female and readmitted on [DATE] with a diagnosis of chronic non-pressure ulcer of right and left foot (an open sore on the foot that does not heal due to poor circulation, nerve damage, or repeated pressure). Record review of Resident #1's quarterly MDS dated [DATE], indicated Resident #1 was understood and understood others. Resident #1 had a BIMS score of 2 indicating she had severe cognitive impairment. The MDS also indicated Resident #1 required moderate assistance with toileting. The MDS indicated Resident #1 had 1 unhealed pressure ulcer. Record review of Resident #1's care plan initiated 3/4/2026 indicated Resident #1 had surgical site to right inferior breast with interventions to observe for signs and symptoms of infection, report to physician if noted, observe for signs and symptoms of pain during treatment and medicate as needed per physician orders, surgeon follow up as needed, assist resident, RP with scheduling/transportation as needed and complete wound care per orders. There were no care plan or orders for enhanced barrier precautions for Resident #1 with chronic wounds. During an observation on 6/24/2026 at 9:29 AM, CNA D was observed walking down the hallway with a mask on with gloves holding a soiled brief in her hands. CNA D removed gloves and threw them in the trash. During an observation on 6/24/2026 at 9:40 AM, LVN C was observed walking down hallway putting on her gloves prior to arriving to Resident #1's room. LVN C was observed cleaning Resident #1's toilet with cleaning wipes. LVN C then left Resident #1's room and removed gloves outside the room while walking down the hallway. LVN C was observed returning to Resident #1's room and new gloves placed on prior to arriving to room. LVN C did not wash her hands or apply PPE while transferring Resident #1 to the toilet. LVN C was contacted for a phone interview on 6/25/2026 at 3:54 PM and did not receive a return call at end of investigation. During an observation on 6/24/2026 at 9:45 AM, ADON arrived at Resident #1's room. ADON did not wash hands prior to assisting LVN C transferring Resident #1 on/off the toilet. ADON was not wearing PPE while assisting Resident #1 who was on Enhanced Barrier Precautions. due to chronic wound to right breast. ADON left the room with gloves on and trash from resident room. ADON removed gloves in hallway while throwing away the trash and then used hand sanitizer. ADON returned to Resident #1's room with briefs and gloves to assist with applying new brief. ADON did not (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675177
		If continuation sheet Page 1 of 3

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 06/25/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	apply PPE during brief change. During a telephone interview on 6/24/2026 at 10:39 AM, Resident # 1's RP said staff had not been wearing PPE while providing care. During an interview on 6/25/2026 at 8:15 AM, Resident #1 said she had a wound to her right breast and stated it had been there for a while. Resident #1 said the staff were performing wound care daily. Resident #1 said the staff did not wear PPE while providing care. During an observation and interview on 6/25/2026 at 3:13 PM, LVN B was requested by RP to check Resident #1's skin to her bottom. LVN B arrived at Resident #1's room and applied gloves. LVN B assisted Resident #1 from her wheelchair to her bed by pivoting her with close contact and direct assistance. LVN B was asked to step out of room prior to skin assessment. LVN B was made aware of EBP. LVN B said she got distracted and forgot to put on PPE. LVN B returned to room after applying PPE and new gloves. RP asked LVN B why she was wearing PPE and informed LVN no staff had used gowns while assisting Resident #1. LVN B explained PPE was worn while providing direct care contact for residents who had IV therapy, catheters, or wounds. LVN B told RP the precautions were to protect the residents from staff germs. During an interview on 6/25/2026 at 3:20 PM, LVN B said she should have applied PPE prior to entering Resident #1's room. LVN B said Resident #1 could get an infection. LVN B said staff should not wear gloves while walking down the hallway or removing gloves or PPE in the hallway. LVN B said it could cause cross contamination. LVN B said she had been in-serviced on PPE and EBP. LVN B said everyone was responsible for ensuring PPE was worn while providing care to residents on EBP precautions. During an interview on 6/25/2026 at 3:44 PM, CNA D said she should not have worn gloves in the hallway. CNA D said she was going to take her gloves off, but she had a soiled brief in her hand. CNA D said someone had removed her barrel and she took the soiled brief back in the resident's room and took gloves off to get the barrel. CNA D said the soiled brief should have been in a trash bag then placed in the barrel. CNA D said it was an infection control issue and wearing gloves and having a soiled brief spread infection. CNA D said she did wash her hands after she threw the brief away. CNA D said she had only worked at the facility for a couple of weeks. CNA D said she had been trained on EBP and PPE. CNA D said she did not know what types of residents required PPE. CNA D said she had a couple of residents who were on precautions and staff put on gowns while care provided. CNA D said a staff should wear PPE while assisting a resident on EBP to the bathroom. CNA D said she was responsible for ensuring EBP precautions were followed. CNA D said not following EBP could negatively impact a resident and could cause a spread of infection or bacteria to a resident. During an interview on 6/25/2026 at 4:15 PM, the ADON said she should have worn PPE while providing care to Resident #1. ADON said LVN C should have worn PPE while she was providing care with Resident #1. The ADON said residents with chronic wounds, foley catheters (a medical procedure that involves inserting a catheter into the bladder to drain urine), Gastrostomy tubes (a soft, flexible tube that goes through the abdominal wall directly, creating an opening for feeding and medication delivery), or Jackson Pratt (JP) drains (a surgical device use to remove excess fluid from a wound after surgery) require EBP and staff should be washing their hands and applying gloves and PPE. The ADON said the PPE should be worn while transferring a resident to the toilet. The ADON said she should have been prepared. The ADON said residents on EBP have a sign on the door. The ADON said staff should not apply gloves in the hallway or remove gloves in the hallway. The ADON said the staff should be washing hands in resident room before coming out of the room. The ADON said it was all the team's responsibility to ensure PPE was being worn properly. The ADON said she was responsible for the in-services. The ADON said not following EBP could cause the spread of infection causing a resident to become sick. The ADON said gloves and briefs should not be removed outside a resident room unless in a trash bag and placed in the gray barrel. During a phone interview on 6/25/2026 at 4:31 PM, the DON said PPE should be worn with residents with wound care or had if a staff would be in contact with bodily fluids. The DON said PPE should be worn with residents with chronic wounds. The DON said she expected staff to follow EBP. The DON said the staff are starting to get back in the habit of wearing PPE and she said she had observed staff follow EBP. The DON said she expected staff to (continued on next page)		

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 06/25/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know what types of residents required EBP and she expected staff to wear PPE. The DON said staff should not be wearing gloves or carrying soiled briefs in the hallway. The DON said she expected the nurse to wash hands and apply gloves prior to care and stated the gloves were at the door. The DON said she expected the nurse to remove their gloves prior to leaving the resident room. The DON said the nurse should have worn PPE while providing a skin assessment. The DON said she was responsible for educating and ensuring staff were wearing proper PPE and following EBP. The DON said it could cause a resident to get an infection or spread to other residents. During an interview on 6/25/2026 at 4:42 PM, the ADM said she expected staff to wear PPE and following EBP. The ADM said the department heads, nursing and Infectious Disease Preventionist was responsible for ensuring PPE was worn and EBP was followed. The ADM said she expected staff to wash their hands before and after caring for a resident and for staff not to be wearing PPE in the hallway. The ADM said if staff were not wearing PPE while providing care, staff members could cross-contaminate the resident receiving care. Record review of a facility policy titled Enhanced Barrier Precautions dated 4/1/2025 indicated .Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targets gown and glove during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE. EBP are indicated for residents with any of the following: .colonization with SDS-targets MDRO when contact precautions do not otherwise apply. wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. Donning PPE for Residents on EBP based on Activity provided/assistance while in resident room. performing wound care: any opening requiring a dressing. transfer a resident. changing briefs or assisting with toileting. turn and repositioning or assist with bed mobility. bathing/showering. providing hygiene. changing linens. device care. any high contact. Disposal of PPE. PPE used during resident care, including care of residents placed on Enhanced Barrier Precautions are not regulated medical waste requiring disposal in a biohazard bag, and should be disposed as routine non-infectious waste. Communication to Staff. facility will utilize posting outside the room and EMR to communicate to staff if a resident requires EBP. Record review of a facility policy titled Fundamentals of Infection Control Precautions dated undated indicated .A variety of infection control measures are used for decreasing the risk and transmission of microorganisms in the facility. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. coming on duty. visibly soiled. before performing any invasive procedure. before entering isolation precaution setting. eating or handling food. before and after assisting resident with personal care. before inserting indwelling catheter. after handling soiled or used linens, dressings, soiled equipment. after removing gloves or aprons. Recommended techniques for washing hands with soap and water. Gloving are worn for three important reasons. 1. To provide protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions. 2. To reduce likelihood of that microorganism, present on the hands of personnel will be transmitted to resident's mucous membranes. 3. To reduce the likelihood of that hands of personnel contaminated with microorganisms from a resident or a fomite can transmit these microorganisms to other residents.		