STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interviews and record reviews the facility failed to coordinate assessments with pre-admission screening and resident review (PASRR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort which included referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 of 5 residents (Resident #61) reviewed for PASRR Level I screenings. The facility failed to ensure the correct PASRR (a preliminary assessment completed for all individuals before admission to a Medicaid-certified nursing facility to determine whether they might have a mental illness or intellectual disability) Level 1 Screening was submitted to the local authority for Resident #61 who had a diagnosis of mental illness upon admission. This failure could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings include: Record review of Resident #61's face sheet dated 01/15/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung diseases that block airflow and make it difficult to breathe), bipolar disorder (mental illness that causes extreme shifts in mood, energy, and activity levels), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and depression (persistent feeling of sadness and loss of interest that can interfere with daily activities). Record review of Resident #61's admission MDS assessment dated [DATE], indicated Resident #61 was able to make herself understood and understood others. Resident #61 had a BIMS score of 10, indicating her cognition was moderately impaired. The MDS indicated Resident #61 had an active diagnosis of bipolar disorder and had received antipsychotic medication within the last 7 days of the 7-day look back period. Record review of Resident #61's comprehensive care plan dated 12/29/24, indicated Resident #61 required anti-psychotic medications. The care plan interventions included to administer medications as ordered, monitor/record occurrence of target behavior symptoms, and to monitor/record/report to medical director as needed side effects and adverse reactions of psychoactive medications. (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
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #61's PASRR Level 1 Screening form dated 11/20/24, indicated Resident #61 had no evidence or indicator of a mental illness. Record review of Resident #61's order summary report dated 01/15/25, indicated she had an order for quetiapine (antipsychotic medication) 100mg give one tablet by mouth one time a day for anxiety related to bipolar disorder with an order date of 11/27/24. Record review of Resident #61's medication administration record dated 01/01/25- 01/31/25, indicated she had received quetiapine 100mg one tablet by mouth daily for anxiety related to bipolar disorder. During an interview on 01/15/25 at 10:22 AM, MDS Coordinator D said when a resident admitted to the facility and their PASRR did not indicate they had a mental illness, they would not know if a corrected PASRR Level 1 needed to be completed. MDS Coordinator D said since Resident #61 had a diagnosis of mental disorder then a Form 1012 or a new PASRR level 1 screening form should have been completed. MDS Coordinator D said since she missed Resident #61 diagnosis of bipolar disorder, Resident #61 did not have a positive PASRR level 1 screening. This placed Resident #61 at risk for not receiving PASRR services through the local authority. MDS Coordinator D said she was responsible for ensuring the PASRR Level 1 Screening forms were completed correctly . During an interview on 01/15/25 at 3:27 PM, the DON said he was not familiar with the PASRR process. The DON said the MDS Coordinator was responsible for completing the PASRR Level 1 Screening forms accurately. The DON said by not completing the PASRR Level 1 screening correctly and the resident was positive for a mental illness they could fail to address the resident's mental health. During an interview on 01/15/25 at 4:02 PM, the Administrator said she expected the policy for PASRR to be followed as well as the regulation. The Administrator said if a resident had a history of mental health, then the PASRR Level 1 screening should be addressed and followed up on. The Administrator said the MDS Coordinator was responsible for ensuring the PASRR Level 1 Screenings were completed accurately so the residents received the services they need to maintain their highest level of functioning. Record review of the facility's policy and procedure, PASRR Level 1 Screen Policy and Procedure, indicated . it is the policy of [same corporate owned healthcare facilities] to obtain a PL1 screening form from the referring entity prior to the Nursing Facility . The PASRR Program is important because it provides options for individuals to choose where they live, who they live with and the training and therapy they need to live as independently as possible . 3. The facility will review the PL1 Screening Form for completion and correctness prior to admission and submit the PL1 form per regulations . review each item on the PL1 to ensure accuracy and prevent a regulatory problem .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 of 6 (Resident #9) residents reviewed for the care plans. The facility failed to ensure a fall mat was beside Resident #9's bed as stated in her care plan. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: Record review of Resident #9's face sheet, dated 01/15/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Dementia (loss of memory, language, problem-solving and other thinking abilities that were severe enough to interfere with daily life), Bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood), depression (low mood), and high blood pressure. Record review of Resident #9's quarterly MDS assessment, dated 11/25/24, indicated Resident #9 usually makes herself understood and understood others. Resident #9's BIMS score was 06, which meant she was severely cognitively impaired. The MDS indicated Resident #9 required help with toileting bed mobility, dressing, transfers, personal hygiene, and eating. The MDS indicated she had a fall on a prior assessment. Record review of Resident #9's physician's order dated 02/23/24 indicated: May have a fall mat at the bedside every shift. Record review of Resident #9's comprehensive care plan, with a revised date of 12/24/24, indicated Resident #9 had a diagnosis of insomnia (a sleep disorder that makes it hard to fall or stay asleep) and was at risk for impaired sleep pattern, mood swings, and increased risk for falls. The intervention was to apply a fall mat at the bedside. During an observation on 01/14/25 at 10:44 a.m., Resident #9 was lying in her bed with no fall mat on the floor next to her bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/15/25 at 8:48 a.m., Resident #9 was lying in her bed with no fall mat noted at the bedside. Resident #9's roommate said Resident #9 had a fall mat but unknown date of when she saw it last. The roommate said Resident #9 had attempted to get up in the past, but she would push her call light for someone to help her. CNA I came to Resident #9's room and verified Resident #9's fall mat was not placed beside the bed. She said she knew Resident #9 had a fall mat and should have had a fall mat beside her bed because she was at risk of falling. LVN E looked at Resident #9's electronic medical records and verified Resident #9 had an order for a fall mat at the bedside. LVN E said she started working on Resident #9's hall in November of 2024 but could not remember if she ever saw a fall mat for Resident #9 . During an interview on 01/15/25 at 2:48 p.m., the DON said if a resident had an order for a fall mat, then they should have one beside the bed. He said the nurse who received the order should have placed the fall mat beside the bed, and nurse managers should follow up to ensure it was beside the bed. He said if the fall mat was not in place, the residents could have a greater risk of hurting themselves when falling out of bed. During an interview on 01/15/25 at 3:10 p.m., the Administrator said she expected a fall mat to be in place if the resident had an order. She said she wanted doctor's orders to be followed. She said the charge nurse should verify the fall mat every shift, and the ADON/DON oversees the process. She said a fall mat was placed to prevent an injury as much as possible. Record review of the facility policy titled, Physician's Orders, from the Medical Records Manual dated 2015, indicated, The Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. Record review of the facility policy titled, Preventive Strategies to Reduce Fall Risk, from The Fall Risk Mini Manual revised October 5, 2016, indicated, The Policy: The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility. Procedure: 1. After risk is assessed, individualized nursing care plans will be implemented to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects. Record review of the facility policy titled, Comprehensive Care Planning, from The Nursing Policy & Procedure Manual section 03-18.0 indicated, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following -o The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review the facility failed to ensure the residents environment remained free of accident hazards by not adequately monitoring the proper storage of oxygen cylinders for 1 of 2 residents (Resident #62). The facility failed to ensure the oxygen cylinder in Resident #62's room was properly secured. This failure could place the resident at risk for injury. Findings included: Record review of Resident #62's face sheet dated 01/15/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #62 had diagnoses which included dementia (memory loss), chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), osteoporosis (condition when bones become weak and brittle), and hallucinations (a perception of having, seen, heard, touched, tasted, or smelled something that was not actually there). Record review of Resident #62's quarterly MDS assessment dated [DATE], indicated Resident was able to be understood and was able to understand others. Resident #62 had a BIMS score of 8, indicating her cognition was moderately impaired. Resident #62 required supervision or touching assistance with toileting hygiene, showering, and lower body dressing. The MDS did not indicate Resident #62 required oxygen therapy. Record review of Resident #62's comprehensive care plan dated 09/09/24 indicated Resident #62 had emphysema (chronic lung disease that damages the air sacs in the lungs, making it difficult to breathe)/COPD with interventions to give oxygen therapy as ordered by the physician. Record review of Resident #62's order summary report dated 01/15/25, did not indicate Resident #62 had orders for oxygen therapy . During an observation and interview on 01/13/25 at 12:23 PM, Resident #62 was lying in her bed. Resident #62 said she had just returned from the hospital. Resident #62 had a free-standing portable oxygen cylinder sitting on the floor in front of her bedside commode that was on her right side of her bed. Resident #62 said the person who brought her in to her room placed the portable oxygen cylinder on the floor next to her bed. Resident #62 said she did not use oxygen. During an observation on 01/14/25 at 08:20 AM, Resident #62 was in lying in her bed. Resident #62 was not wearing any oxygen. The oxygen cylinder continued to be free standing on the floor to the right side of her bed. During an observation on 01/14/25 at 12:55 PM, Resident #62 was in lying in her bed. Resident #62 was not wearing any oxygen. The oxygen cylinder continued to be free standing on the floor to the right side of her bed . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/25 at 12:57 PM, LVN B said she was responsible for taking the portable oxygen cylinder out of Resident #62's room but forgot. LVN B said portable oxygen cylinders should never be free standing as they could fall over, bust and cause an accident. LVN B said portable oxygen cylinders should be secured in a little rack or on the back of a wheelchair. LVN B said it was the nurse's responsibility to ensure the oxygen cylinders were properly secured. During an interview on 01/15/25 at 3:27 PM, the DON said the portable oxygen cylinders should not be freestanding and should be secured in the oxygen room, the back of the wheelchair in a secure holder, or in the oxygen rollers. Failure to properly secure the portable oxygen cylinders could cause the cylinder to fall over, becoming a projectile and cause injury to a resident. The DON said any staff member was responsible for ensuring the portable oxygen cylinders were properly secured. During an interview on 01/15/25 at 4:02 PM, the Administrator said she expected the portable oxygen cylinders to be appropriately stored and should not be freestanding. The Administrator said if the oxygen cylinder needed to be in a room, it should be on a rolling holder, secured to the back of the wheelchair or stored in the oxygen closet. The Administrator said the resident was at risk of injury if the oxygen tank fell . The nurses were responsible for ensuring the portable oxygen cylinders were stored appropriately. Record review of facility's policy, Oxygen Administration, revised March 21, 2023, indicated . Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases . Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident's bed or concentrator . e. If a small cylinder is used, position and secure it in a portable cart .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practices for 1 of 65 residents (Resident #35) reviewed for respiratory care. The Facility failed to ensure Resident #35 nebulizer mask was bagged when not in use. This failure could place residents who receive respiratory care at risk for developing respiratory complications. The findings included: Record review of the profile sheet, dated 1/15/25, revealed Resident #35 was an [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease with acute lower respiratory infection(COPD) (an inflammatory lung disease that causes obstructed airflow from the lungs), unspecified dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and hypertension (high blood pressure). Record review of the MDS quarterly assessment, dated 11/29/24, revealed Resident #35 had clear speech, was understood, and made himself understood. The MDS revealed Resident #35 had a BIMS of 12, which indicated moderate cognitive impairment. The MDS revealed Resident #35 had no behaviors or refusal of care. Record review of the comprehensive care plan, completed on 12/16/24, revealed Resident #35 had Emphysema/COPD. The care plan interventions were, Resident #35 will be monitored/document for anxiety; Offer support, encourage resident to vent frustrations, fears; Monitor/document/report to MD PRN any signs and symptoms of respiratory infection: Fever, Chills, increase in sputum (document the amount, color, and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing. Record review of the Medication Review dated 1/15/25, revealed Resident #35 had a physician's order, which started on 07/17/24, for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol). The medication Review indicated Resident #35 was to take one vial inhale orally two times a day for short of breath (SOB). During an observation on 1/13/25 at 11:23 a.m., Resident #35 was laying in his bed with the head of bed elevated at approximately 45 degrees. Resident was not using his nebulizer machine. Nebulizer machine was sitting near bed side on top of the resident's dresser. Nebulizer mask and tubing were sitting inside resident junk drawer near bedside. Nebulizer mask did not have the label with the resident room number and name. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/14/25 at 11:23 a.m., Resident #35 was laying in his bed with the head of bed elevated at approximately 45 degrees. Resident was not using his nebulizer machine. Nebulizer machine was sitting near bed side on top of the resident dresser. Nebulizer mask and tubing were sitting inside resident junk drawer near bedside. Nebulizer mask did not have the label with the resident room number and name. During an interview on 1/14/25 at 2:21 p.m., Resident #35 stated he used his nebulizer machine twice a day. Resident #35 stated after use of his nebulizer machine the staff never bagged his nebulizer mask after use. During an interview on 1/15/25 at 10:35 a.m., LVN E stated she had been employed at the facility for at least 1 year. LVN E stated she worked the 6 am to 6 pm shift. LVN E stated she was responsible for ensuring the masks were being bagged when not in use. LVN E stated she was not aware of Resident #35 nebulizer mask not being bagged after use nor being labeled with the patient's name and room number. LVN E stated she conducted rounds between 6am to 9 am, 2 pm and 4 pm to 6pm. LVN E stated she was not aware of any recent in-services. LVN E stated, It was important to ensure the mask was being bagged for infection control and I e would not want to use a mask that everything had been on it. During an interview on 1/15/25 at 11:20 a.m., the DON stated he had been employed at the facility for 5 weeks. The DON stated he was not aware Resident #35's nebulizer machine and mask were not being bagged or labeled with the resident name and room number. The DON stated the nebulizer and masks should have been bagged. The DON stated he oversaw the nursing department. The DON stated to his knowledge in-services had not been completed on nebulizers. The DON stated he was ultimately responsible for ensuring the nebulizer and mask were labeled and bagged. The DON stated, It was important to ensure the nebulizer was bagged and labeled with the resident room number and name for infection control, so they are not on the floor and labeled so they don't get mixed up and used on the wrong resident. During an interview on 1/15/25 at 1:57 p.m., the Administrator stated she had been employed since July of 2024. Stated she oversaw the nursing department. The Administrator stated the nebulizer machine and mask should have been bagged and labeled with resident room number and name. The Administrator stated she was not aware of the nebulizer machine and masks not being labeled or bagged after use. The Administrator stated the nursing department was responsible for ensuring the nebulizer and mask were being labeled and bagged after use. The Administrator stated the ADON, DON and she were responsible for ensuring the nebulizer machine and mask were labeled and bagged. The Administrator stated she oversaw the ADON and DON. The Administrator stated the nebulizer machine and masks should be checked during champion rounds each morning. The Administrator stated, It was important to ensure the nebulizer machine and mask were labeled and being bagged after use to help the mask and nebulizer stay clean and make sure that multiple residents were not using someone else's machine and to protect positive outcomes. Record review of Aerosolized Hand-Held Nebulizer dated 2003, indicated, Purpose: To provide guidelines for administration of nebulized medication to patients . (13) Rinse the nebulizer and mouthpiece shake and store in a plastic bag that is labeled with the patient's name and room number.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interview, and record review, the facility failed to ensure dialysis services were provided consistently with professional standards of practice for 1 of 1 resident reviewed for dialysis services. (Resident #21) 1. The facility failed to ensure the dialysis communication forms were fully completed to include the post dialysis assessment for Resident #21. 2. The facility failed to ensure the dialysis order was updated when Resident #21's dialysis days changed on [DATE]. This failure could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: Record review of Resident #21's face sheet, dated [DATE], reflected Resident #21 was a [AGE] year-old female who initially admitted to the facility on [DATE] with a diagnosis of end stage renal disease (occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state). Record review of the significant change MDS assessment, dated [DATE], reflected Resident #21 had clear speech and was understood by staff. The MDS reflected Resident #21 was able to understand others. The MDS reflected Resident #21 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #21 had no behaviors or refusal of care. The MDS reflected Resident #21 received dialysis while a resident at the facility. Record review of the comprehensive care plan, last revised on [DATE], reflected Resident #21 received hemodialysis two times per week on Tuesday and Thursday. Record review of the Pre/Post Dialysis Communication Report forms for Resident #21, from [DATE], [DATE], and [DATE], reflected Resident #21 had a missing post dialysis assessment (completed by the facility staff) for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Record review of the order summary report, dated [DATE], reflected Resident #21 had an order for Hemodialysis on Monday, Wednesday, and Friday effective [DATE]. Record review of the social service progress note, dated [DATE], reflected Resident #21's dialysis chair time was changed effective [DATE] to Tuesday, Thursday, and Saturday. Record review of the nursing progress note, dated [DATE], reflected Resident #21's dialysis chair time was decreased to 2 times per week on Tuesday and Saturday. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE], beginning at 10:22 AM, Resident #21 stated she received dialysis two times per week on Tuesday and Saturday. Resident #21 stated she recently started dialysis in the last few months. Resident #21's dialysis catheter was located on her chest, which was completely covered by a dressing dated [DATE]. Resident #21 stated the dialysis center changed the dressing. Resident #21 stated the facility staff looked at her port but did not mess with it. Resident #21 stated she took the dialysis communication forms with her to the dialysis and returned them to the facility staff when she arrived back at the facility. Resident #21 was unsure if a post-dialysis assessment was completed when she returned to the facility. During an interview on [DATE] beginning at 4:07 PM, LVN B stated when Resident #21 returned from dialysis she checked her vital signs and filled out the post dialysis communication form. LVN B stated Resident #21 recently changed her chair time and days of dialysis. LVN B stated prior to the last few weeks, Resident #21 returned from dialysis on the night shift around 7 PM. LVN B was unsure why the post-dialysis assessments were not completed. LVN B stated it was important to ensure a post-dialysis assessment was completed to monitor Resident #21's status after dialysis. LVN B said it was important to monitor Resident #21's condition because it could have changed quickly, and she could have died . LVN B stated the orders should have reflected Resident #21's current dialysis schedule. LVN B stated any nurse was responsible for ensuring the orders were updated and correct. LVN B said it was important to ensure the dialysis order was accurate so everyone was aware when Resident #21's dialysis should have been completed. LVN B said if the orders were not updated it placed Resident #21 at risk for missing dialysis treatment. During an interview on [DATE] beginning at 4:14 PM, the DON stated the nurse receiving Resident #21 back from dialysis was responsible for ensuring the post dialysis assessment was completed. The DON stated he expected the nurses to ensure the post dialysis assessments were completed and filled out on the dialysis communication form. The DON stated he currently had no process in place for monitoring to ensure post-dialysis assessments were completed. The DON stated it was important to ensure post dialysis assessments were completed and the communication forms were filled out for continuity of care and monitoring for changes in the resident's condition. The DON stated he expected the nurses to ensure the dialysis orders were updated and changed as ordered by the physician. The DON stated it was important to ensure dialysis orders were updated to prevent the residents from missing dialysis. The DON stated it placed the residents at risk for fluid overload and other issues caused from not receiving dialysis treatment. During an interview on [DATE] beginning at 4:31 PM, the Administrator stated she expected the nursing staff to ensure dialysis orders were updated and the post dialysis assessments were completed and documented on the dialysis communication form. The Administrator stated the nursing management was responsible for monitoring to ensure the orders were updated and the post dialysis assessment was completed and documented on the communication form. The Administrator stated it was important to ensure the post dialysis assessment was completed to monitor a change in the resident's condition. The Administrator stated it was important to ensure dialysis orders were updated to ensure compliance with the regulations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Dialysis policy, revised ,d+[DATE], reflected review and confirm the physician's order for dialysis .the facility will establish baseline information from the dialysis center and will monitor changes from the baseline .the facility will assist the resident as needed with making an appointment at the dialysis center as specified by physician order .the facility will document the resident's vital signs, general appearance, orientation, and additional baseline data as needed. The resident's clinical record will be documented with this information .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 1 storage area reviewed for expired and discontinued medications and for the accuracy of administering drugs and biologicals to meet the needs of each resident for 1 of 8 residents (Resident #10) reviewed for insulin administration. 1.The facility failed to keep a record of a receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. 2. The facility failed to ensure LVN E primed Resident #10's insulin pen of Fiasp (a rapid-acting insulin) before given. These failures could place residents at risk of not receiving the therapeutic benefit of medications, loss of prescribed medications and drug diversion. Findings included: 1.During an observation and interview on [DATE] at 1:05 p.m., the following unlogged medications were observed in the controlled medications storage area waiting to be disposed of: *Tylenol/Codeine ,d+[DATE] milligrams--- 58 tablets *Hydrocodone ,d+[DATE] milligrams---32 tablets *Temazepam 30 milligram 8 tablets *Tramadol HCL 50 milligram 30 tablets *Morphine Sulfate ER 60 milligram 28 tablets *Hydrocodone Tylenol ,d+[DATE] milligrams 30 tablets *Lyrica 75 milligram 6 capsules *Tramadol HCL 50 milligram---9 tablets *Tylenol/codeine ,d+[DATE] milligram---39 tablets *Lorazepam 0.5 milligram ---45 tablets *Morphine Sulfate Solution ,d+[DATE] milligram--- 19 milliliters (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Zolpidem 10 milligrams ---12 tablets *Lorazepam 0.5 milligram --- 41 tablets *Tramadol HCL 50 milligram ---42 tablets *Tramadol HCL 50 milligram ---30 tablets *Morphine Sulfate Solution ,d+[DATE] milliliters --- 29 milliliters *Hydromorphone 2 milligrams --- 30 tablets *Tylenol/Codeine ,d+[DATE] milligram--- 32 tablets *Tramadol HCL 50 milligram--- 23 tablets *Morphine Sulfate ER 60 milligram--- 30 tablets *Morphine Sulfate Solution ,d+[DATE] milliliters --- 30 milliliters *Lorazepam 0.5 milligram--- 21 tabs *Hydrocodone ,d+[DATE] milligrams---30 tablets During an interview on [DATE] at 1:05 p.m., the DON said the process for reconciled medications that needed to be disposed of was for the nurses to let him know when a medication had been discontinued or a resident had expired. He said he would get the medication and sign off on the narcotic sheet with the nurse indicating how many medications were left, he said then he would log the medication. The DON opened his locked cabinet and revealed an unknown number of medications that were not logged on the drug destruction sheet. The DON said he had not had time to log the medication, therefore the medication log was not up to date. He said his last drug destruction was on [DATE] and no meds had been logged since then. He said he was not sure about the destruction policy, but he said he would look. He said he always tried to log the medications when he received them, but he had a lot of residents who either discharged or expired. The DON said he was responsible for logging the medication when it was brought to him. The DON said by not logging the medications there was a risk for medications to come up missing. Record review of the facility's medication destruction binder on [DATE] indicated the last medication destruction was completed on [DATE]. 2. Record review of Resident #10's face sheet, dated [DATE], indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Metabolic encephalopathy (a condition where the brain does not function properly due to an imbalance in the body's metabolism), Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and high blood pressure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #10's quarterly MDS assessment, dated [DATE], indicated Resident #10 understood and was understood by others. Resident #10's BIMS score was 11, which meant she was moderately cognitively impaired. The MDS indicated Resident #10 required help with toileting, dressing, and bathing. The MDS indicated she took insulin medication during the 7-day look-back period. Record review of Resident #10's Physician order dated [DATE] indicated: Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 units per milliliter (Insulin Aspart (with Niacinamide), Inject 12 units subcutaneously three times a day related to diagnosis of Diabetes. Record review of Resident #10's comprehensive care plan, dated [DATE], indicated Resident #10 had Diabetes Mellitus. The interventions were to administer medication as ordered and monitor/document for side effects and effectiveness. During an observation and interview on [DATE] at 4:45 p.m., LVN E went to take Resident #10's blood sugar. The reading was 340. She reviewed the order and it read to give 12 units of Fiasp. LVN E turned the insulin pen to 12 units and gave the insulin to Resident #10. LVN E did not prime the insulin pen. LVN E said she had never primed her insulin pen and was not aware she needed to. During a phone interview on [DATE] at 1:32 p.m., the facility's Pharmacist said nurses should check the blood sugar and then the order. She said they should then prime the insulin pen to ensure it was working properly. She said failure to check the insulin pen before use could cause the insulin pen not to deliver the correct dose. She said the DON was responsible for overseeing the expired or discontinued medications. She said then the DON was responsible for logging it on the destruction sheet and keeping it under double lock until she came to destroy it . During an interview on [DATE] at 2:48 p.m., the DON said he expected the nurses to administer the insulin correctly. He said they should verify the order, wipe the end of the insulin pen, apply the needle, and give the medication. The DON said he was not aware that the nurses should prime the insulin pen before use. He said after reading the guidelines about how the insulin pen should be primed first, he said it was important for the residents to receive the correct amount of insulin to prevent hyper (too high blood sugar) or hypoglycemia (too low blood sugar). He said he had not done any skill checkoff since employment 5 weeks ago, but he had done periodical checks on staff. He said skill checks should be done yearly and as needed. During an interview on [DATE] at 3:10 p.m., the Administrator said she expected the expired or discontinued narcotics to be given to the DON with the narcotic count sheet. She said she expected the DON to log the narcotic medications as soon as possible and give her a copy each time. She said it was the DON's responsibility to ensure the process was being completed. She said failure to follow the process could lead to medications being taken, lost, or not destroyed properly. The Administrator said she expected staff to administer insulin correctly. She said if they did not prime or check the insulin pen it could deliver too much or not enough medication which could cause the resident sugar to rise or be lowered. She said the ADON/DON was the overseer of the insulin process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Drug Destruction Policy, from the Pharmacy Policy & Procedure Manual 2003, revised [DATE], indicated It is the policy of this facility to destroy dangerous and controlled medications according to the State of Texas law. 2. Drugs to be destroyed will be destroyed under the supervision of a consultant pharmacist and at least one of the following: Director of Nursing, Assistant Director of Nursing, or Administrator. 3. Nursing staff will submit to the Director of Nursing any medication and any applicable log that has expired, been discontinued by the physician or that had been prescribed to a resident who no longer resides at the facility. 4. The nurse submitting the discontinued medication, will verify along with the Director of Nursing that the amount of medication remaining matches the log. After verification, both the nurse and the Director of Nursing will sign the log. 5. The nurse will make a copy of the signed log and provide it to the administrator. The Director of Nursing will maintain the original log and medication. 6. The Director of Nursing will log medications submitted for destruction. All medications submitted to the Director of Nursing will be kept under double-lock system Record review of the facility policy titled, Insulin pen Use from the Pharmacy Policy & Procedure Manual 2003 revised [DATE], indicated, Always attach a new needle before each use. Always perform the safety test before each injection. Do not select a dose or press the injection button without a needle attached. This pen is only for one resident's use. Never use an insulin pen if it is damaged or if you are not sure that it is working properly. Never withdraw insulin from the insulin pen with a needle and syringe this will affect the structural integrity of the insulin pen and could possibly introduce contaminates. Step 1 Check the insulin, Step 2. Attach the needle. Step 3. Perform a Safety test: Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly and removing air bubbles. A. Select a dose of 2 units by turning the dosage selector. B. Hold the pen with the needle pointing upwards. C. Tap the insulin reservoir so that any air bubbles rise towards the needle. D. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. If no insulin comes out, check for air bubbles, and repeat the safety test two more times to remove them. If still no insulin comes out, the needle may be blocked. Change the needle and try again

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on interviews and record review, the facility failed to act upon the recommendations of the pharmacist report of irregularities for 3 of 5 residents (Resident's #17, #52, and #56) reviewed for (DRR) Drug Regimen Review. 1. The facility failed to provide documentation of the pharmacy recommendation or rationale for an attempted gradual dose reduction for Resident #17's risperidone (antipsychotic medication), Resident #52's buspirone (antianxiety medication), and Resident #56's paroxetine (antidepressant medication). 2. The facility failed to ensure the Pharmacist Consultant addressed Resident #56's buspirone (antianxiety medication) for a gradual dose reduction. This failure could place residents at risk for receiving unnecessary medications at the most effective dosage. The findings included: 1. Record review of the face sheet, dated 01/15/25, reflected Resident #17 was a [AGE] year-old female who initially admitted to the facility on [DATE] with a diagnosis of bipolar disorder (mental health condition characterized by significant mood swings). Record review of the quarterly MDS assessment, dated 01/07/25, reflected Resident #17 had clear speech and was understood by others. The MDS reflected Resident #17 was ablet to understand others. The MDS reflected Resident #17 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #17 had no behaviors or refusal of care. The MDS reflected Resident #17 had an active psychiatric/mood disorder. The MDS reflected Resident #17 was taking an antipsychotic medication during the 7-day look-back period. Record review of the order summary report, dated 01/15/25, reflected Resident #17 had an order for risperidone 1 mg (antipsychotic medication) give 1 tablet by mouth twice a day related to bipolar disorder effective 12/09/23. Record review of the MAR, dated January 2025, reflected Resident #17 received risperidone (antipsychotic medication) twice a day. Record review of the comprehensive care plan, reviewed 12/31/2024, reflected Resident #17 required antipsychotic medication. The interventions included: consult with pharmacy .consider dosage reduction when clinically appropriate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the psychotropic medication utilization report dated 11/06/24, reflected Resident #17 had an order for antipsychotic medication, risperidone, with an ordered date of 12/09/23 and a GDR date of 11/05/24. The report indicated the next GDR request was on 11/30/25. The pharmacy GDR recommendation for Resident #17's antipsychotic could not be located in the pharmacy recommendations nor Resident #17's electronic medical records. 2. Record review of the face sheet, dated 01/15/25, reflected Resident #52 was an [AGE] year-old female who initially admitted to the facility on [DATE] with a diagnosis of unspecified dementia with no behaviors (loss of cognitive functioning that interferes with daily life and activities). Record review of the significant change MDS assessment, dated 11/30/24, reflected Resident #52 had clear speech and was understood by others. The MDS reflected Resident #52 was able to understand others. The MDS reflected Resident #52 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS reflected Resident #52 had no behaviors or refusal of care. The MDS reflected Resident #52 received an antianxiety medication during the 7-day look-back period. Record review of the order summary report, dated 01/15/25, reflected Resident #52 had an order for buspirone (antianxiety medication) 5 mg - give one tablet by mouth two times a day for anxiety. Record review of the MAR, dated January 2025, reflected Resident #52 received an antianxiety medication twice a day. Record review of the comprehensive care plan, reviewed on 12/11/24, reflected Resident #52 used antianxiety medications for adjustment issues and anxiety disorder. The interventions included: give medications as ordered by the physician and monitor and document side effects and effectiveness. Record review of the psychotropic medication utilization report dated 11/06/24, indicated Resident #52 had an order for an antianxiety medication, buspirone with an ordered date of 05/29/23 and a GDR date of 11/05/24. The report indicated the next GDR request was on 11/30/25. The pharmacy GDR recommendation for Resident #52's buspirone could not be located in the pharmacy recommendations nor Resident #52's electronic medical records. 46928 3. Record review of Resident #56's face sheet dated 01/15/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #56's diagnoses included dementia (memory loss), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and depression (persistent feeling of sadness and loss interest that interferes with day-to-day activities). Record review of Resident #56's quarterly MDS assessment dated [DATE], indicated Resident #56 was able to make herself understood and understood others. The MDS assessment indicated Resident #56 had a BIMS score of 11, indicating her cognition was moderately impaired. The MDS indicated Resident #56 had active diagnoses of anxiety and depression. The MDS indicated Resident #56 had received antianxiety and antidepressant medications within the last 7 days of the 7-day of the look back period. Record review of Resident #56's order summary report dated 01/15/24, indicated Resident #56 had orders the following orders: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Buspirone 10mg give 2 tablets by mouth 3 times a day for anxiety disorder with a start date of 11/15/23. 2. Paroxetine 10mg give one tablet by mouth one time a day for other specified depressive disorders with a start date of 11/16/23. Record review of Resident #56's medication administration record dated 01/01/25-01/31/25, indicated Resident #56 had received paroxetine 10mg one time a day for other specified depressive disorders and buspirone 10mg 2 tablets by mouth three times a day for anxiety disorder. Record review of Resident #56's comprehensive care plan dated 07/30/24, indicated Resident #56 had a mood problem with interventions to administer medications as ordered. Record review of the psychotropic medication utilization report dated 11/06/24, indicated Resident #56 had an order for antidepressant medication, paroxetine, 10mg give one tablet by mouth one time a day for other specified depressive disorders with an ordered date of 11/16/23 and a GDR date of 11/05/24. The report indicated the next GDR request was on 05/30/25. The pharmacy GDR recommendation for Resident #56's paroxetine could not be located in the pharmacy recommendations nor Resident #56's electronic medical records. During an interview on 01/15/25 beginning at 12:45 PM, the Administrator stated the facility staff were unable to locate the pharmacy recommendations for November 2024. The Administrator stated she was unsure if any changes or gradual dose reductions for psychotropic medications were implemented or if a rational was documented by the physician. During an interview on 01/15/25 beginning at 1:16 PM, the Pharmacy Consultant stated the timeframe for implementing a gradual dose reduction or pharmacy recommendation was 24 to 48 hours. The Pharmacy Consultant stated the facility has had some turnover recently with the DONs and she believed the ADON had been working night shift a lot. The Pharmacy Consultant stated she has had to teach the process for pharmacy recommendations with each new DON and believed the lack of consistent staff had made it hard to implement and monitor the pharmacy recommendations. The Pharmacy Consultant stated she expected the facility staff to ensure the physician was reviewing the recommendations and documenting a rational for non-attempts of gradual dose reduction. The Pharmacy Consultant stated it was important to ensure pharmacy recommendations were followed up on and gradual dose reductions were documented to make sure the residents were monitored. The Pharmacy Consultant stated it was important to ensure the residents were taking the least amount of medication at the most therapeutic dosage for them. The Pharmacy Consultant stated she was unaware Resident #56 was taking buspirone. The Pharmacy Consultant stated buspirone was an antianxiety medication. The Pharmacy Consultant stated a gradual dose reduction should had been attempted twice in the first year it was prescribed and then annually thereafter. The Pharmacy Consultant stated it was important to ensure psychotropic drug monitoring was implemented to ensure the resident needed the medication and to monitor for side effects related to drug use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/15/25 beginning at 2:01 PM, the Medical Director stated he spent most of his time at the facility completing and signing the pharmacy recommendations. The Medical Director stated the facility staff tracked him down to ensure the recommendations were signed and completed. The Medical Director stated if he disagreed with the recommendations for a gradual dose reduction, he always documented a rational. The Medical Director stated he expected the facility staff to ensure pharmacy recommendations were included as part of the medical record. The Medical Director stated it was important to ensure documentation of the pharmacy recommendations were kept as proof the residents' medications were being monitored. During an interview on 01/15/24 beginning at 3:27 PM, the DON said GDR reductions should be completed by the physician. The DON said the residents' medications should be reviewed for possible dosage reduction. The DON said the process when pharmacy recommendations were received was as follows: the DON received the recommendations from the Pharmacy Consultant, he then made a copy of the recommendations and sent one to the physician and kept one for himself, as signed recommendations came in, he would then check them off. The DON said the physician had to review them within 30 days or before the next recommendations were received. The DON said by not completing a gradual dose reduction a resident could be receiving a medication that could be therapeutic at a lesser dose, be more alert and more active. The DON said he was responsible for ensuring the pharmacy recommendations were being implemented. During an interview on 01/15/24 at 04:02 PM, the Administrator said she expected the residents' medications to be reviewed monthly by the Pharmacy Consultant. The Administrator said the pharmacy recommendations for gradual dose reductions should be discussed with the physician and the physician should provide a rationale for his decisions. The Administrator said the Pharmacist should have been aware Resident #56 had been receiving buspirone. The Administrator said failure to address medications for gradual dose reductions could place residents at risk for not having a medication regiment that was optimal to receive the best outcomes. The Administrator said the pharmacy recommendations were received by the ADON and the DON should have ensured the accuracy. The Administrator said they currently did not have an ADON. During an interview on 01/15/25 beginning at 4:31 PM, the Administrator stated the Pharmacy Consultant should have reviewed the resident's medications every month and sent a list of pharmacy recommendations to the nurse management. The Administrator stated the nursing management was responsible for ensuring the Medical Director reviewed, signed, and documented a rational on the recommendations. The Administrator stated the nursing management was responsible for ensuring pharmacy recommendations were carried out. The Administrator stated after all the steps were completed the recommendations should have been uploaded into the medical record. The Administrator stated it was important to ensure gradual dose reductions were attempted on psychotropic medications or a rational was documented to ensure residents were receiving the optimal dosage of medication for good outcomes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Psychotropic Drugs, revised 10/25/17, indicated . The intent of this policy is that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing, the facility implements gradual dose reductions (GDR) . A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic . The facility will ensure that .2. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; (Refer to Medication Review policy and behavior management policy) . The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident . During the monthly medication regimen review, the pharmacist evaluates resident-related information for dose, duration, continued need, and the emergence of adverse consequences for all medications .Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record review the facility failed to ensure all drugs were only accessible by authorized personnel, for 1 of 6 residents (Resident #54), 3 of 6 medication carts (Halls 500, 100, and 200), and 1 of 1 treatment cart reviewed for storage of medications. 1. The facility did not ensure medication was not left unattended on Resident #54's bedside table. 2. The facility failed to ensure LVN E kept the 500-hall medication cart secured and was unable to be accessed by unauthorized personnel. on 01/14/25. 3. The facility failed to ensure LVN A kept the Hall 1 and 2 nurse medication carts locked or within her line of sight when not in use on 01/13/25. 4. The facility failed to ensure the Treatment Nurse locked the treatment cart when she left it unattended in the hallway on 01/15/25. These failures could place residents at risk of not receiving the therapeutic benefit of medications, harm or misuse of medication, drug diversions, and adverse reactions to medications due to improper storage. Findings included: 1.Record review of Resident #54's face sheet, dated 01/15/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem-solving, and other thinking abilities that were severe enough to interfere with daily life), bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood) and depression (low mood), schizophrenia (a chronic mental illness characterized by disruptions in thought processes, perceptions, emotions, and social interactions), and high blood pressure. Record review of Resident #54's quarterly MDS assessment, dated 10/29/24, indicated Resident #54 understood and was understood by others. Resident #54's BIMS score was 08, which meant she was moderately cognitively impaired. The MDS indicated Resident #54 required help with toileting, bed mobility, dressing, transfers, personal hygiene, and eating. The MDS indicated she took antidepressant medication during the 7-day look-back period. Record review of Resident #54's Medication Administration Record for the 6 pm-6 am shift dated 01/01/25 thru 01/31/25 indicated: Mirtazapine Oral Tablet 15 MG (Mirtazapine), Give 1 tablet by mouth one time a day related to unspecified protein-calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen), Give 1 tablet by mouth two times a day for pain related to orthopedic surgery. Trazodone HCl Oral Tablet 50 MG (Trazodone HCl), Give 0.5 tablet by mouth at bedtime for insomnia (a sleep disorder that makes it hard to fall or stay asleep). Record review of Resident #54's comprehensive care plan, dated 07/02/24, indicated Resident #54 had impaired cognitive function or impaired thought processes related to a dementia diagnosis. The interventions were to administer medications as ordered. During an observation and interview on 01/14/25 at 9:46 a.m., Resident #54 was in her bed and 3 unidentified pills were noted sitting in a cup on her bedside table. Resident #54 said LVN G had given her those medications last night, but she refused to take them. LVN F came into the room and verified Resident #54 had 3 unidentified pills sitting on her bedside table. LVN F reviewed Resident #54's medication and identified 1 pill as Mirtazapine because of its oval shape and a V symbol printed on the pill. LVN E was unable to identify the other 2 pills. LVN F said it was important to stay with the resident until they took their medication to prevent another (confused) resident from wandering and taking the wrong medication. During an attempted phone interview on 01/14/25 at 10:53 a.m., called LVN G with no answer, a message was left. During an interview on 1/15/25 at 2:48 p.m., the DON said he expected staff not to leave medication at the bedside unattended. The DON said the nurse who gave the medication was responsible for ensuring the resident took his or her medication before leaving the room. He said he would do an in-service. He said during the investigation process he had identified LVN H and not LVN G as the nurse who left the medication at the bedside. He said he had not done checkoffs on medication administration with the nurses since he had started working for the facility 5 weeks ago. He said if medications were left at the bedside, then the intended resident would not receive their medication which could cause physical or psychological effects depending on the medication(s) ordered. During an attempted phone interview on 01/15/25 at 3:04 p.m., called LVN H, and a message was left. During an interview on 01/15/25 at 3:10 p.m., the Administrator said she did not expect medication to be left at the bedside because part of medication administration was to ensure the resident took or refused his or her medication. She said if medication was left at the bedside, then other residents were at risk of getting medication that was not ordered for them or even staff. She said they verified staff was competent through medication passes on hire, annual, and visual checks. 2. During an observation and interview on 01/14/25 at 9:52 a.m., LVN E was standing at the 500-hall medication cart and walked away. This state surveyor observed a resident, CNA I, and a maintenance person walk by the unlocked cart. LVN E then went to another cart on the hallway and retrieved medication to give to Resident #46. LVN E walked into Resident #46's room to administer his medication while leaving the 500-hall medication unlocked and out of her sight. LVN E said she should have locked her cart when not using the cart for the safety of others. 47006 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation on 01/13/25 beginning at 9:52 AM, Hall 1 and 2 nurses medication cart was sitting in front of the nurses' station and was not locked. There were 2 nurses sitting behind the nurses' station and unable to visualize the front of the cart from the sitting area. Multiple staff members, residents, and visitors passed by the unlocked cart. During an interview on 01/13/25 beginning at 9:58 AM, LVN A stated she was unaware her medication cart was unlocked. LVN A immediately locked the medication cart. LVN A stated she had just given her keys to the corporate lady because she was looking at the expiration dates. LVN A stated she threw the keys back at her when she was done looking through it but must have forgotten to lock it. LVN A stated she did not check to ensure the medication cart was locked. LVN A stated she did not normally leave her cart unlocked. During an observation on 01/13/25 at 11:11 AM, Hall 1 and 2 nurses medication cart was sitting in front of the nurses' station and was not locked. LVN A had exited the bathroom and stated the DON was going to get onto her. LVN A stated she had just given him some discontinued narcotic medication off the cart and forgot to lock it. LVN A immediately locked the medication cart. 46928 4. During an observation and interview on 01/15/25 at 10:48 AM, the Treatment Nurse left the treatment cart unlocked and unattended on hall 2, when she left to find a staff member to assist her in providing a wound care treatment for a resident. The Treatment Nurse said she started on Monday 01/13/25 and she did not have a key to the treatment cart until that morning. She said she was responsible for ensuring the cart was locked when left unattended. She said by leaving the cart unlocked someone could get in, steal a medication, or consume something dangerous, or something they were allergic to. During an interview on 01/15/25 beginning at 1:16 PM, the Pharmacy Consultant stated she had observed unlocked medication and treatment carts at the facility during her visits. The Pharmacy Consultant stated she expected the nursing staff to ensure their medication or treatment carts were locked when they were not being used. The Pharmacy Consultant stated it was important to ensure medication and treatment carts were locked to prevent unauthorized persons from taking medications. The Pharmacy Consultant stated a resident could have taken medications from the cart if it was unlocked. During an interview on 01/15/25 beginning at 4:14 PM, the DON stated he expected medication or treatment carts to remained locked when the nursing staff were not actively using the cart or when they walked away from the cart. The DON stated everyone was responsible for monitoring to ensure medications or treatment carts were locked. The DON stated it was important to ensure medication and treatment carts remained locked to prevent a drug diversion or residents from taking medications that could have caused harm. During an interview on 01/15/25 beginning at 4:31 PM, the Administrator stated she expected nursing staff to ensure the medication or treatments carts remained locked if they were not standing at the cart working. The Administrator stated nursing management was responsible for monitoring to ensure medication and treatment carts were locked. The Administrator stated she was responsible for overseeing the nursing management team. The Administrator stated it was important to ensure medication or treatment carts to remained locked for resident safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/15/25 beginning at 5:14 PM, LVN A stated she was unsure what the corporate lady's name was. LVN A stated she was busy and nervous on 01/13/25 when the medication carts were left unlocked. LVN A stated it was important to ensure the medication carts remained locked when not in use to prevent missing medications or resident injury. During an interview on 01/15/25 beginning at 5:17 PM, the Corporate Nurse stated she did not believe she was the one who left the medication cart unlocked on 01/13/25. The Corporate Nurse stated she was looking in the Hall 1/2 medication nurse cart with the DON and it could have been either one of them. The Corporate Nurse stated she expected the medication carts to be locked at all times. The Corporate Nurse said it was important to ensure medication carts were kept locked to prevent hazards. Record review of the Storage of Medication policy, year dated 2003, reflected Medication rooms, carts, and medication supplies are locked and attended by persons with authorized access .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47708 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 3 meals reviewed. The dietary staff failed to provide food that was palatable for 1 of 3 meals observed on 1/14/25 (lunch) meal. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: Record review of the menu indicated the lunch meal items on 1/14/25 included beef steak, mash potatoes, spinach, dinner roll, and cheesecake. Record review of the Dietary staff in-services indicated Recipe in-service was last completed on July 2, 2024. During an interview on 01/13/2025 beginning at 10:09 AM, Resident #43 stated the food was too salty. During an interview on 1/13/25 at 11:18a.m., Resident # 38 stated the food was not good. During an interview on 1/13/25 at 11:23 a.m., Resident # 50 stated the food was cold. During an interview on 1/14/25 at 08:56 a.m., Resident #268 stated the food was not warm when he got it. During an interview on 1/14/25 at 2:34 p.m., Resident #50 stated her spinach was too salty but everything else was good for the lunch meal served on 1/14/25. During observation and tasting of lunch meal on 1/14/25 at 12:26 p.m., the Dietary Manager stated the beef steak was cooked good and the beef steak did not taste salty to her; the spinach was good and not salty; mash potatoes were warm and good; cheesecake was good; and the dinner roll was buttery. During observation and tasting of lunch meal on 1/14/25 at 12:26 p.m., four State Surveyors stated beef steak was too salty; the mash potatoes were good and warm; the spinach was warm but salty; cheesecake was good; and the dinner roll was good and buttery. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/25 at 11:07 a.m., the Dietary Manager stated she had been the Dietary Manager for 5 years. The Dietary Manager stated the Administrator oversaw her at the facility. The Dietary Manager stated she tasted the food all the time prior to serving. The Dietary Manager stated staff had been in-serviced on following the recipe book in the past. The Dietary Manager stated she handled all food complaints. The Dietary Manager stated if a resident stated they did not like the meal serving that she would always offer a substitute meal. The Dietary Manager stated she always had a regular and alternate meal at every lunch and dinner. The Dietary Manager stated the cook was upset that the meat and spinach were too salty. The Dietary Manager stated it was important to ensure the food was palatable, attractive, and appetizing to the resident so the residents will eat the foods and not lose weight. During an interview on 1/15/25 at 1:44 p.m., the Administrator stated she had been employed since July 2024. The Administrator stated she oversaw the Dietary Manager. The Administrator stated she had ordered test trays from the kitchen at least quarterly. The Administrator stated she based her test tray assessment from the residents. The Administrator stated the residents in the past had complained of the food at the facility. The Administrator stated the Dietary manager handled all complaints at the facility. The Administrator stated in-services on following the recipe book, she believed had been completed within the last 6 months. The Administrator stated, It was important to ensure the food was palatable, attractive, and appetizing because so many things surround nutrition and when food was palatable, attractive, and appetizing then the residents were more likely to eat the food and avoid negative outcomes. The Administrator stated the facility did not have policy on palatability. The Administrator stated, Regarding palatability, we follow the recipe. 47006

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services. 1) The facility failed to dispose of expired food items. 2) The facility failed to clean the bread [NAME] storage container, microwave, can opener, and utensil drawer. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During an observation in the kitchen of Refrigerator 1 of 2 on [DATE] at 9:56 a.m., the following were observed: -(1) container of carrots had a prep date of [DATE] and use by date of [DATE]. (expired) During observation in the kitchen dry storage area on [DATE] at 10:15 a.m., the following were observed: -(1) container of bread crumps was empty; container had not been cleaned. During an observation in the kitchen on [DATE] at 10:20 a.m., the following were observed: - Dirty can opener with food debris on the can opener knife. - Utensil drawer had food debris inside the drawer. -The microwave had food debris on the plate and in the inside of the microwave. During an interview and observation of the kitchen and dry storage area on [DATE] at 10:15 a.m., the Dietary Manager stated the food items did not have to include a use by or expiration date. The Dietary Manager stated the can opener was dirty and needed to be cleaned. The Dietary Manager stated the utensil drawer needed to be cleaned. The Dietary Manger stated staff had just wasted crumbs in the utensil drawer and the utensil drawer would be cleaned today ([DATE]). The Dietary Manager stated the microwave needed to be cleaned and was last used today on [DATE]. The Dietary Manager stated the Dietary staff should have cleaned the can opener and microwave after each use. During a follow up visit of the kitchen on [DATE] at 11:34 a.m., the utensil drawer had not been cleaned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on [DATE] at 11:34 a.m., the Dietary Manager stated the cook had forgot to clean the utensil drawer yesterday (on [DATE]). The Dietary Manager was observed cleaning the utensil drawer. During an interview on [DATE] at 11:11 a.m., The Dietary Manager stated the Administrator oversaw her. The Dietary Manager stated she had been employed at the facility for 5 years. The Dietary Manager stated that the dietary staff did label and date the food. The Dietary Manager stated the dietary staff never put open date on the food. The Dietary Manager stated she oversaw the dietary staff. The Dietary Manager stated she was responsible for ensuring expired foods were exposed of and the kitchen was cleaned daily. The Dietary Manager stated staff sometimes was in a hurry and did stupid stuff. The Dietary Manager stated she was not aware of when in-services were last completed on discarding expired food items, labeling, and dating. The Dietary Manager stated she conducted walk throughs in the kitchen every morning. The Dietary Manager stated she saw the expired carrots in the refrigerator prior to survey but saw a one for the month and not a 12 as listed on the carrots. The Dietary Manager stated left over food was good for 7 days. The Dietary Manger stated that the mistake of leaving the expired carrots in the refrigerator was on her and not the dietary staff. The Dietary Manager stated it was important to ensure the food items were labeled, dated, and expired foods were discarded to make sure the dietary staff were not serving bad foods. During an interview on [DATE] at 1:51 p.m., the Administrator stated she had been employed since July of 2024. The Administrator stated she oversaw the Dietary Manager. The Administrator stated all food items were to be discarded at expiration date. The Administrator stated she conducted walk throughs in the kitchen at least 4 times a week. The Administrator stated she was not made aware of the finding found in the kitchen prior to survey. The Administrator stated she expected the Dietary staff to follow the dietary policy. The Administrator stated she expected the Dietary Manager to report all findings found in the kitchen. The Administrator stated, It was important that staff were cleaning the kitchen a discarding expired foods to prevent negative resident outcome. During record review of the Dietary Services Policy & Procedure Manual dated 2012 revealed, (6) When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate when the product was manufactured, not when it expires and should not be interpreted as a best by or use by date. Best by or use by dates indicate when a product will have best flavor or quality and are not an indicator of the product's safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year. After one year, any product that is shelf stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once that date passes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 5 residents (Resident #s 12 and 46) reviewed for infection control. 1. The facility failed to ensure CNA C changed her gloves when she provided incontinent care to Resident #12 on 01/13/25. 2. The facility failed to ensure CNA C did not apply the dirty linen that had fallen to the floor on 01/13/25 to Resident #12. 3. The facility failed to ensure LVN E wore a gown when she gave Resident #46 his medication through his gastrostomy (also known as a G-tube, is a thin, flexible tube inserted through the abdominal wall directly into the stomach used to provide nutrition and medications directly to the stomach when a person is unable to eat or drink adequately by mouth). These failures could place residents and staff at risk for cross-contamination and the spread of infection. Findings included: 1. Record review of Resident #12's face sheet dated 01/15/24, indicated an [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #12 had diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), difficulty walking, weakness, need for assistance with personal care, and anxiety (intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #12's quarterly MDS assessment dated [DATE], indicated Resident #12 was able to make herself understood and understood others. Resident #12 had a BIMS score of 8, indicating her cognition was moderately impaired. Resident #12 required substantial/maximal assistance with toileting hygiene, bathing, and lower body dressing. Resident #12 was frequently incontinent of urine and occasionally incontinent of bowel. Record review of Resident #12's comprehensive care plan dated 11/02/20, indicated she had bladder incontinence, activity intolerance, and impaired mobility. The care plan interventions indicated for incontinent care at least every 2 hours and apply moisture barrier after each episode. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 - Few	During an observation and interview on 01/13/25 at 2:15 PM, CNA C entered Resident #12's room to provide incontinent care. CNA C washed her hands and applied gloves. CNA C proceeded to provide incontinent care and apply barrier cream to Resident #12. CNA C never changed her gloves throughout the incontinent care process. CNA C removed the fitted sheet from under Resident #12 and placed it on the end of the bed. Using the same dirty gloves, CNA C obtained a clean fitted sheet and a flat sheet from the clean linen bag she had brought in the room. Two clean pillowcases and one flat sheet fell on the floor. CNA C applied the clean fitted sheet, flat sheet, and the clean brief. CNA C removed her gloves after she fastened Resident #12's clean brief. CNA C proceeded to pick it up, the linen from the floor, and applied it to Resident #12. CNA C completed applying covers to Resident #12 and then washed her hands. CNA C said when she provided incontinent care, she usually just used one set of gloves for the whole process. CNA C said she was unaware of when to change her gloves but believed after removing the dirty brief and before applying the clean brief. CNA C said she should have not applied the linen that fell on the floor to Resident #12 because it was considered dirty. CNA C said failure to change gloves and applying dirty linen placed Resident #12 at risk for infection and cross contamination. CNA C said she was responsible for ensuring proper incontinent care and clean linens were provided to the residents. During an interview on 01/15/25 at 3:14 PM, LVN B said she expected CNA C to have changed her gloves when she was going from dirty to clean. LVN B said clean linen that has fallen to the floor was considered dirty and should not be placed on the resident. LVN B said by not changing their gloves and placing dirty linens, while providing care to a resident, was cross contamination and placed the resident at risk for infection. LVN B said the CNA providing care was responsible for ensuring proper incontinent care and clean linens were being provided to the residents. During an interview on 01/15/25 at 03:27 PM, the DON said he expected the staff to change their gloves when their gloves become soiled or before touching clean linen. The DON said failure to change gloves when going from dirty to clean or applying dirty linen was cross contamination. The DON said the staff member providing the care was responsible for providing proper incontinent care and ensuring the linen was clean before applying it to the resident. During an interview on 01/15/25 at 4:02 PM, the Administrator said she expected incontinent care to be provided with dignity and privacy as well as following the policy and procedure to maintain infection control practices. The Administrator said CNA C should have changed her gloves when going from dirty to clean and failure to do so could cause infections. The Administrator said she expected CNA C to have obtained clean linens and not to have applied the linen that had fallen to the floor to Resident #12. The Administrator said the linen that had fallen to the floor was considered contaminated. The Administrator said the CNAs were responsible for ensuring infection control was maintained when providing care to a resident and the charge nurse and the DON were responsible for supervising. 45879 2. Record review of Resident #46's face sheet, dated 01/15/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease also known as PD (is a chronic and progressive neurological disorder that affects movement, balance, and coordination), dysphagia (difficulty swallowing), and gastroesophageal reflux disease also known as GERD (is a chronic digestive condition that occurs when stomach contents flow back up into the esophagus). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 - Few	Record review of Resident #46's quarterly MDS assessment, dated 12/05/24, indicated Resident #46 usually understood and was understood by others. Resident #46's BIMS score was a 03 indicating he was severely cognitively impaired. The MDS indicated he required total assistance with all his ADLs. The MDS indicated Resident #46 had a gastrostomy. Record review of Resident #46's Physician order dated 10/07/24 indicated: Jevity 1.5 via tube feeding (gastrostomy tube) at 60 milliliters per hour with a water flush of 50 milliliters per hour. Record review of Resident #46's Physician order dated 01/13/25 indicated: Carbidopa-Levodopa 25-100 milligram, Give 2 tablets enterally three times a day for Parkinson's disease. Record review of Resident #46's comprehensive care plan dated 07/24/24 indicated, he required Enhanced Barrier Precautions. The interventions were for staff to wear gloves and gown if any of the following activities were to occur such as linen changes, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. During an observation on 01/14/25 at 9:51 a.m., Resident #46 had a sign for Enhanced Barrier Precautions also known as EBP which indicated they recommended staff to wear gowns and gloves while providing care for any resident who had any of the following: 1) infection or 2) a wound or indwelling medical device, even if the resident was not known to be infected, outside his door. During an observation and interview on 01/14/25 at 9:52 a.m., LVN E entered Resident #46's room to administer his morning medication of Carbidopa-Levodopa 25-100 milligram with gloves on. She did not apply her gown before entering Resident #46's room or before giving his medication. LVN E said she knew Resident #46 was on EBP and that a gown and gloves should be worn to protect the resident. She said she did not wear a gown because she was only giving him his medication and not providing incontinent care. She said she was going to ask someone if she should wear a gown and gloves when giving gastrostomy medication. During an interview on 01/15/25 at 10:38 a.m., LVN E said she asked the DON if she was supposed to wear a gown and gloves when giving gastrostomy medications and she was told yes. LVN E said she would be wearing a gown and gloves moving forward when giving gastrostomy medications. During an interview on 1/15/25 at 2:48 p.m., the DON said he expected staff to follow the precautions for EBP. He said staff should wear gloves and gowns during high-contact resident care activities for residents to prevent infection and wash their hands before and aftercare. He said he expected LVN E to wear a gown and gloves when giving gastrostomy medication to Resident #46 because of his EBP and to prevent infection from occurring because he had an opening to his skin (gastrostomy). He said he was responsible for ensuring staff was wearing the required PPE and he made random rounds to ensure staff were wearing the appropriate PPE when going into rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 - Few	During an interview on 01/15/24 at 3:10 p.m., the Administrator said all staff were responsible for following infection control practices. She said she expected staff to look at the sign on the door to tell them what they should do, and she expected them to do that. She said she was the infection preventionist and expected the charge nurses to manage the CNAs, the ADON/DON to manage the charge nurses, and she was the overseer of everyone. She said the signs such as EBP or contact were posted on the door of residents who had been identified as people who could potentially get an infection or spread infection. The administrator said if they were not wearing the appropriate PPE then they could spread germs or infection to someone else. Record review of the facility policy titled, Infection Control Plan: Overview, from the Infection Control Policy and Procedure [NAME] dated March 2016, indicated, The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. The Infection Control Program: The facility will establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility. Preventing Spread of Infection: (3) The facility will require staff to wash their hands after each direct resident contact for which hand washing was indicated by accepted professional practice. The intent: is to assure that the facility develops, implements, and maintains an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will: oPerform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection; oPrevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions; oImplement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination. Record review of the facility policy titled, Fundamentals of Infection Control Precautions, from the Infection Control Policy and Procedure [NAME] dated 2019, indicated, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. #1. Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections. #5. Gowns and protective apparel: 1. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF 2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from residents or items in their environment to other residents or environments; when gowns are worn for this purpose, they are removed before the personnel leave the resident's environment. Record review of the facility's undated policy Linens indicated . 1. Resident linens must be clean and dry and changed regularly . Employees will ensure that hands are clean and dry before handling clean linen . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 - Few	Record review of the facility's policy and procedure, Perineal Care effective 05/11/22, indicated . This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition . 21) Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area . 23) Note skin changes and apply moisture barrier cream as directed 24) Doff gloves and PPE 25) Perform hand hygiene .Doffing and discarding of gloves are required if visibly soiled . Always perform hand hygiene before and after glove use .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on interviews, and record review, the facility failed to ensure that each resident was offered a pneumococcal immunization, unless the immunization was medically contraindicated, or the resident had already been immunized for 1 of 5 resident's (Resident #16) reviewed for pneumococcal vaccinations. The facility failed to ensure Resident #16 was offered the pneumococcal vaccination in accordance with the CDC schedule and timing for the pneumococcal vaccine. This failure could place residents at risk for contracting a viral disease that could spread through the facility and cause respiratory complications, and potential adverse health outcomes. The findings included: Record review of the face sheet, dated 01/15/25, reflected Resident #16 was an [AGE] year-old female who initially admitted to the facility on [DATE] with a diagnosis of asthma (condition in which your airways narrow and swell and may produce extra mucus). Record review of the significant change MDS assessment, dated 01/05/25, reflected Resident #16 had unclear speech and was rarely or never understood by others. The MDS reflected Resident #16 was sometimes able to understand others. The MDS reflected Resident #16 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS reflected Resident #16 had an active pulmonary (lung) disease. The MDS reflected Resident #16's pneumococcal vaccination was up to date. Record review of the comprehensive care plan, reviewed 11/21/24, did not address pneumonia vaccinations. Record review of the order summary report, dated 01/15/25, reflected Resident #16 had an order pneumonia vaccine per CDC recommendation. Record review of the Immunization Report, dated 01/13/25, reflected Resident #16 historically received the Prevnar 13 pneumococcal vaccination on 01/01/16. The report reflected no other pneumococcal vaccination was offered, received, or declined. Record review of the Pneumococcal Vaccine Timing for Adults, updated October 2024 and accessed on the cdc.gov/pneumococcal website, reflected Make sure your patients are up to date with pneumococcal vaccination .adults greater than or equal to [AGE] years old . completed pneumococcal vaccine schedules with prior vaccination of Prevnar 13 (at any age) is recommended PCV20 or PCV21 greater than 1 year after the Prevnar 13 vaccination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 beginning at 2:33 PM, the Administrator stated the facility did not have a recent pneumonia vaccination consent or declination form for Resident #16. The Administrator stated pneumonia vaccinations evaluation should have been completed annually. The Administrator stated pneumococcal vaccinations should have been offered per the CDC recommendations. The Administrator stated she was the acting infection control preventionist. The Administrator stated the ADON was the infection control preventionist, but she no longer worked at the facility. The Administrator stated it was important to ensure pneumococcal vaccinations were offered to promote better health outcomes. During an interview on 01/15/25 beginning at 3:42 PM, the DON stated he expected pneumonia vaccinations to have been offered per the CDC recommendations. The DON stated consent or declination forms should have been kept in the medical record. The DON stated if the resident's wanted the pneumonia vaccinations it should have been administered. The DON stated pneumonia vaccinations should be reviewed twice a year to allow the resident's time to rethink or change their mind about the pneumococcal vaccinations. The DON stated it was important to ensure residents received the pneumonia vaccinations to ensure they can live a healthier life, especially in a communal environment where they were more susceptible to illness. Record review of the Resident Influenza and Pneumonia Vaccine policy, undated, reflected it is the policy of this company that all residents will be offered the pneumonia immunization unless the immunization is contraindicated, or the resident has already been immunized .this facility offers the pneumonia vaccines according to ACIP guidelines .