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	03/25/2026

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preference for 1 of 13 residents (Resident #49) reviewed for pain management. The facility failed to ensure Resident #49 received her scheduled pain medication (oxycodone) on the following dates and times:1. On 11/03/25, Resident #49 missed her 2 p.m. dose, which resulted in moderate 5 out of 10 pain on the 1-10 pain scale.2. On 11/13/25, Resident #49 missed her 10 p.m. dose, which resulted in severe 9 out of 10 pain on the 1-10 pain scale.3. On 03/23/26, Resident #49 missed her 6 a.m., dose, which resulted in severe 10 out of 10 pain on the 1-10 pain scale before her medication arrived from the pharmacy. An immediate jeopardy (IJ) was identified on 03/24/26 at 4:10 p.m. The IJ template was provided to the facility on [DATE] at 4:27 p.m. While the IJ was removed on 03/25/26 at 2:34 p.m., the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all nursing staff had not been provided education on pain management, notification of changes of condition, abuse, neglect, and medication administration policy. These failures could place residents at risk of severe, uncontrolled pain, severe mental anguish or emotional distress that could have led to serious harm, injury, impairment, or death. The findings included: Record review of the face sheet, dated 03/24/26, reflected Resident #49 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of morbid (severe) obesity due to excess calories, opioid dependence with withdrawal (dependence on narcotic pain medication), and chronic pain. Record review of the admission MDS assessment, dated 10/07/25, reflected Resident #49 had clear speech, was understood, and was able to understand others. Resident #49 had a BIMS score of 14, which reflected no cognitive impairment. Resident #49 had no behaviors or refusal of care during the look-back period. Resident #49 received PRN pain medication and had occasional pain during the 5 day-look back period. The MDS reflected Resident #49 received opioid pain medication. Record review of the comprehensive care plan, dated 10/06/25, reflected Resident #49 had the potential for uncontrolled pain. Resident #49's pain goal was 0. The interventions included: anticipating the need for pain relief and responding immediately to any complaints of pain, evaluating the effectiveness of pain interventions, monitor/document for side effects of pain medication, and monitor/record/report non-verbal signs or symptoms of pain. Record review of Resident #49's order summary report, dated 03/24/26, reflected an order for oxycodone-Acetaminophen 10-325 mg - Give 1 tablet by mouth three times a day for moderate to severe pain, which was ordered on 10/07/25. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 10/14/25 reflected the 6 a.m. dose given on 10/21/25 was filled out and then marked out as not given. There was no explanation or reason for the mark out. Record review of Pain SBAR, dated 10/20/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was to her lower back. The pain was described as aching and throbbing. She stated the pain was daily, but not constant and lasted 30 - 60 minutes. She stated medications helped relieve the pain. The Medical (continued on next page)

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

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Director was notified on 10/20/25 at 3 p.m. with no new orders given. Record review of the Pain SBAR, dated 10/27/25, reflected Resident #49 had at least one episode of pain that was a 10 or it was described as very severe/horrible. The pain was to her lower back. The pain was described as aching and throbbing. She stated the pain was constant and lasted 30 - 60 minutes. She stated medications helped relieve the pain. The Medical Director was notified on 10/27/25 at 6 p.m. with no new orders given. Record review of Resident #49's MAR, dated October 2025, reflected on 10/21/25 the 6 a.m. dose of oxycodone was signed out as given, which did not match the Individual Control Drug Record form. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 11/03/25, reflected the card of medication was received on 11/03/25 at 2:15 p.m. and had 30 pills. The first dose of oxycodone-acetaminophen was administered at 10 p.m. on 11/03/25. Resident #49 missed her 2 p.m. dose. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 11/14/25, reflected the card of medication was received on 11/14/25 and had 30 pills. The first dose of oxycodone-acetaminophen was administered at 6 a.m. on 11/14/25. Resident #49 missed her 10 p.m. dose on 11/13/25. The 6 a.m. dose of oxycodone-acetaminophen was not signed out on 11/23/25. Record review of the Pain SBAR, dated 11/22/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was generalized and was described as dull, throbbing, tingling. The frequency of pain was less than daily and lasted 30 - 60 minutes. The pain affected sleep, appetite, physical activity, relationships, emotions, and concentration. She stated medications helped relieve the pain. The Medical Director was notified on 11/22/25 at 11:00 a.m. with orders to continue current medications. Record review of the Pain SBAR, dated 11/30/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was to her right lower leg/foot, left lower leg/foot, and generalized. She described the pain as aching, throbbing, burning, and tingling. The frequency of the pain was daily, but not constant and lasted 1 - 2 hours. She stated the pain was affected by increased sadness and emotions. She said the pain affected her sleep, appetite, physical activity, emotions, and concentration. She stated medications helped relieve the pain. The Medical Director was notified on 12/01/25 at 12:00 a.m. (midnight) with no new orders. Record review of Resident #49's MAR, dated November 2025, reflected the following:1. On 11/03/25, the 2 p.m. dose of oxycodone-acetaminophen was not given because medication was unavailable. A tramadol 50 mg (low dose pain medication) was given at 2 p.m. Her pain level was a 5 on 1-10 pain scale.2. On 11/13/25 the 10 p.m. dose of oxycodone-acetaminophen was not given because the medication was unavailable. There was no evidence of additional pain medication given in place of oxycodone on 11/13/25. Resident #49's pain level was not documented. The next pain assessment on 11/14/25 at 6 a.m. indicated her pain level was at a 9 on the 1-10 pain scale.3. On 11/23/25 the 6 a.m. dose of oxycodone-acetaminophen was signed out as given, which did not match the narcotic count sheet. Record review of the Pain SBAR, dated 12/27/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was to her right and left lower leg/foot. The pain was described as throbbing, burning, tingling, sharp, shooting. The frequency of pain was daily, but not constant and lasted 1 - 2 hours. She said the pain affected her sleep, emotions, and concentration. She said the pain was relieved with medications. The Medical Director was notified on 12/27/25 at 12 a.m. (midnight) with no new orders. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 03/23/26, reflected the first pill of 90 was given on 03/23/26 at 3 p.m. when the medication arrived. Resident #49 missed the 6 a.m. dose on 03/23/26. Record review of Resident #49's MAR, dated March 2026, reflected on 03/23/26, Resident #49's 6 a.m. dose of oxycodone-acetaminophen was not given because Other/see nurses note. LVN H signed out a dose of acetaminophen-codeine 300-60 mg dose on 03/23/26 at 6 a.m. Her pain level reflected it was at a 5 on the 1 - 10 pain scale. Record review of the nursing progress notes, dated 02/22/26 to 03/25/26, reflected on 03/23/26 LVN H documented While awaiting pharmacy to deliver [resident] (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	oxycodone, may give [resident] Tylenol #4 [acetaminophen-codeine 300-60 mg] as a replacement to ensure [resident] is not in any pain per [doctor]. During an observation and interview on 03/23/26 beginning at 2:32 p.m., Resident #49 was lying in her bed with the head of her bed elevated slightly. She had a family member in the room during the interview. Resident #49 reported she had not received her scheduled pain medications on several different occasions since she was admitted to the facility. Resident #49 said there was not a place on her body that did not hurt. She said she depended on and needed her pain medication to keep the pain controlled. She said the pharmacy the facility used was in another city and the medications were not readily available. Resident #49 started sobbing. She said she was waiting for her medication that was due at 2 p.m. and had been in pain since this morning. She stated she received a lower level pain pill at 6 a.m. that worked for a short time but had completely worn off during the interview. She stated her pain currently was 10 out of 10 on the pain scale. She said she would never kill herself, but she begged God to take her. She said her pain was exacerbated every time she missed her scheduled pain medication. She said her pain was tolerable at a 4 or 5 on the pain scale. She reported her pain was well-controlled when she received her pain medications as prescribed. Resident #49 stated she felt the facility did not understand her pain and did not try to accommodate her pain needs. She said she was constantly checking with the nurses to ensure she had enough pain medication and would not run out. She said when she runs out of pain medication she becomes frantic and thinks to herself not again, please, not again. During the interview at 3:04 p.m. LVN H knocked, entered Resident #49's room and reported that her pain medication had arrived at the facility and she was going to bring the pill to her. Resident #49 cried with relief that her pain medication was at the facility. During an interview on 03/24/26 beginning at 7:23 a.m., LVN K said Resident #49 complained of pain constantly and took her scheduled and PRN pain medication regularly. She said her pain level was anywhere from 1-10 on the 1-10 pain scale. LVN K stated she had asked the doctor to schedule her PRN pain medication, but he did not want to schedule them. LVN K was unsure if Resident #49 saw a pain management doctor. LVN K stated she was aware two times Resident #49 had run out of her scheduled pain medication but was unaware if Resident #49 had any increased pain. LVN K stated pain was what the patient stated it was. She said Resident #49 needed her pain medications because she constantly hurt. She said she should not have run out of her pain medications but they had trouble getting them from the pharmacy sometimes. During an interview on 03/24/26 beginning at 9:32 a.m., the ADON stated the nurses were responsible for re-ordering narcotic pain medications. She said during the medication pass, if they noticed a medication was getting low, the nurses could go into the electronic charting system and click re-order for the medications that were needed and it would have sent an alert to the pharmacy. She stated if the pain medication had no refills left, then she would have called the pharmacy for approval. She said if a new triplicate was needed, then the doctor had to directly send that to the pharmacy. The ADON stated the doctor usually sent the triplicate for pain medication directly to the pharmacy without any issues. She said if pain medication did run out, the facility had an emergency kit, which had pain medications in it. She said the emergency kit did not have scheduled II medications like oxycodone. She said she was unaware of any residents who had run out of scheduled pain medication. She stated Resident #49's oxycodone had been re-ordered but the delivery drivers' car had broken down on the way. During an interview on 03/24/26 beginning at 12:16 p.m., LVN H stated she did not normally have issues with receiving medication from the pharmacy. LVN H said Resident #49 had run out of scheduled pain medication at least twice that she was aware. LVN H stated if the pharmacy did not get the electronic prescription from the doctor by Friday, then the medication would not have been sent until Monday. LVN H stated Resident #49 received scheduled pain medication three times a day. She said if the nurses waited until the medication card was in the blue (8 pills left) to re-order her medication, then she would not have had enough to last the weekend. LVN H stated she worked on 03/21/26 and realized Resident #49 was not going to have enough medication to last the weekend. LVN H stated she called the pharmacy several times over the weekend, but the pharmacy did not (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	deliver medications on the weekend. She said the medication was supposed to have come in earlier on 03/23/26 but the delivery driver had car trouble. LVN H stated Resident #49 was obsessed with her pain medication. She stated Resident #49 had chronic pain and she received her scheduled and PRN pain medications around the clock to keep her pain under control. She said when Resident #49 did not receive her pain medication, her pain became out of control and took a while to get back under control. She said on 03/23/26 she obtained an order for acetaminophen-codeine 300-60 mg x 1 dose to give in place of her missed oxycodone. She stated Resident #49 reported the pill was effective. She said as soon as Resident #49's oxycodone arrived from the pharmacy, she administered it. LVN H stated there were no set days to re-order medication, but the medications were re-ordered as it was noticed they were getting low. During an interview on 03/24/26 beginning at 1:09 p.m., the DON stated she was aware that Resident #49 had run out of medication on 03/23/26. She said the facility attempted to get the medication STAT 'ed but the driver had car trouble. She said she was unaware Resident #49 was having severe, uncontrolled pain because she had missed her pain medication. She was unaware of any other times Resident #49 had gone without her pain medication. The DON stated any missed dose of pain medication would have made it harder to maintain her desired pain level. She stated pain was what the resident said it was. She said pain was monitored every shift and when any pain medication was administered. The DON stated this was documented on the MAR. She stated severe or uncontrolled pain should have been reported to the doctor. The DON stated when the nurses were passing medications and the medications were getting low; they should have marked re-order in the electronic charting system. She stated the recommended re-order time was when the medication had approximately 8 pills left. She said marking re-order in the electronic charting system, sent the order directly to the pharmacy. She stated the cut off time for re-ordering medications was 6 p.m., so she expected staff to ensure ordering was completed before 6 p.m. She said no medications were delivered on the weekend, unless they were ordered STAT and the facility paid a fee. She said if the medication required a triplicate, the nurses should have notified the Medical Director so he could send the triplicate to the pharmacy. The DON stated the Medical Director did not send Resident #49's triplicate to the pharmacy until 8 or 9 p.m. on 03/20/26, which was past the cut off time, so it was not scheduled for delivery until 03/23/26. She said it was important to ensure medications were ordered timely, so they did not run into issues with medications running out. During an interview on 03/24/26 beginning at 1:31 p.m., the Administrator stated she expected pain was what the patient said it was. She stated she expected resident's pain to be controlled and kept under control. She said the nurses were responsible for monitoring to ensure resident's pain was kept under control. She said she expected the nurses to monitor the resident's pain at least every shift. She said she expected the nurses to ensure severe or uncontrolled pain was reported to the doctor immediately. She said the ADON and DON were responsible for monitoring the nurses. The Administrator stated it was important to ensure pain was kept under control to maintain a resident's pain at a lower level. She said once a resident's pain becomes severe, it was harder to get it back under control. During an interview on 03/24/26 beginning at 2:00 p.m., the Medical Director stated when a medication that required a triplicate was running low, the facility notified him by telephone or fax. He said he liked the facility to send the request at least 24 hours in advance, so he had time to complete the request. The Medical Director stated the facility was pretty good about letting him know ahead of time but there have been a few instances where he was not notified timely. He was unsure of any incidents recently with Resident #49. He believed the facility did not have a systemic issue. The Medical Director stated he had sent a triplicate for Resident #49 within the last week but was unsure if she went without any medication. The Medical Director stated he was unaware Resident #49 had been in severe, uncontrolled pain. He said he would like to have been notified if a resident's pain medication were unavailable. He said he could have found alternate ways to obtain the medications even during the weekend. The Medical Director stated it was important to ensure pain medication was given as ordered to prevent an increase in pain symptoms. He stated it was important to maintain resident's (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	pain at a comfortable level and pain was what the patient said it was. Record review of the Pain Management, Assessment Scale policy, undated, reflected Pain is a subjective sensation of discomfort derived from multiple sensory, nerve interactions generated by physical, chemical, biological, or psychological stimuli. complaints of pain will be assessed accordingly by the nurse and effectively managed through prescribed medications, and comfort measures, and all available resources of the facility. assess resident's physical symptoms of pain, physical complaints, and daily activities. perform comfort measures to promote relaxation.ask resident to help establish goals and develop plan for pain control.this gives the resident sense of control.assist the resident in maintaining a pain management. medication regimen.monitor for effectiveness of pain interventions. The Administrator was notified on 03/24/26 at 4:25 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided with the Immediate Jeopardy template on 03/24/26 at 4:27 p.m. and a plan of removal was requested. The following plan of removal was submitted by the facility and accepted on 03/25/26 at 11:12 a.m. and included the following: Interventions:Resident #49 was assessed for pain by the DON. The [Medical Director] was notified. No complaints of pain or additional issues noted. Resident #49 has pain medication ordered and in facility. No new or worsening pain nor emotional stress at this time. Completion date 3/24/26.Psychological services were provided to Resident # 49 to address any psychological effects related to not receiving pain medications. A telehealth visit was completed on 3/24/26 with the resident and no further orders received. Resident initially started on this service 1/8/26 and a new referral was made 3/24/26 by DON to address any psychological issues related to not receiving scheduled pain medication.A trauma informed care assessment was completed on 3/24/26 by the social worker on Resident #49 for any psychological effects related to not receiving pain medications. No additional psychological effects were expressed or identified. No additional residents were identified as not receiving medications.All residents in the facility were assessed for any increased pain by the DON and Charge Nurses as of 3/24/26. No additional residents with new or uncontrolled pain were identified. Completion date 3/24/26.All residents that receive narcotic medications were audited by the DON/ADON/Regional Compliance Nurse to ensure that at least a 7 day supply are available on the medication carts. All residents have the appropriate amount of medications available as of 3/24/26. Completion date 3/24/26.The DON/ADON/or designee will be responsible for counting all narcotic medications daily to ensure at least a 7 day supply is available on the medication carts. Completion 3/24/26.The DON/ADON/or designee will be responsible for calling the physician when a 10 day supply of medication is on the cart to obtain the triplicates needed to reorder narcotic medications to ensure a 7 day supply is available. Completion 3/24/26.In-services: The Compliance Nurse will in-service the Administrator/DON/ADON 1:1 on the following topics on 3/24/26.Administering pain medication for residents with signs and symptoms of pain and monitoring for effectiveness of PRN medications.Pain management Policy -Signs and symptoms of pain verbally and non-verbal. (Change in behaviors such as crying, whining, groaning, facial expressions, grimacing, frowning, protecting body movements, guarding, or clutching)Notification of a Change of Condition Policy- to the charge nurse or physician immediately including signs and symptoms of increased pain. Abuse and Neglect Policy - to include failure to administer pain medications could be considered neglect.Medication Administration Policy- to include controlled medications, medication reconciliation, and documentation both on the MAR and count sheet.All charge nurses and medication aides were in-serviced on 3/24/26 by the Compliance Nurse/DON/ADON regarding the following topics below. All charge nurses, including agency staff, new hires and PRN charge nurses not in-serviced by 3/24/26 will not be allowed to work in their assigned position until completion of these in-services: Completion as of 3/25/26 DON and ADON were in-service by Compliance Nurse.Administering pain medication for residents with signs and symptoms of pain and monitoring for effectiveness of PRN medications.Pain management Policy -Signs and symptoms of pain verbally and non-verbal. (Change in behaviors such as crying, whining, groaning, facial expressions, grimacing, frowning, protecting body movements, (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	guarding, or clutching)Notification of a Change of Condition Policy- to the charge nurse or physician immediately including signs and symptoms of increased pain. Abuse and Neglect Policy - to include failure to administer pain medications could be considered neglect.Medication Administration Policy- to include controlled medications, medication reconciliation, and documentation both on the MAR and count sheet.The medical director was notified on 3/24/26 of the immediate jeopardy situation by the Administrator.An AD HOC QAPI meeting was held on 3/24/26 by the Interdisciplinary Team to discuss the immediate jeopardy and review the plan of removal for pain. The Administrator and DON will implement this written Plan of Removal and will continue to monitor completion and compliance of this written Plan of Removal. On 03/25/26 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the immediate jeopardy (IJ) by: 1. Record review of Resident #49's pain assessment, dated 03/24/26, reflected Resident #49 had the ability to communicate and her pain was an 8 on the 1-10 pain scale at the time of the assessment. Her pain intensity was at a 10 on the 1-10 pain scale in the last 24 hours. The pain was all over and in her lower back. She described the pain as sharp and constant, lasting 2-4 hours. The pain affected sleep, appetite, physical activity, and emotions. Interventions included scheduled & PRN medications. 2. Record review of the Trauma Informed PRN Assessment, dated 03/24/26, reflected Resident #49 had had a mental disorder but no diagnosis of post-traumatic stress disorder. The assessment did not indicate Resident #49 had any psychological effects from pain. 3. Record review of Resident #49's nursing progress note, dated 03/25/26, reflected the DON had documented Counseling services completed a telehealth session with resident at 6 p.m. on 03/24/26. Resident requested that this nurse stay present in the room. Upon beginning of session, resident asked the counselor if he was the person she could get to order her something stronger than [Tylenol #4], if they make a [Tylenol #5], that would be great. When questioned on her pain at the time of the session, resident stated that she currently didn't have any pain as she had received her PRN medication about 40 minutes prior to start of session, but stated that at the time of receiving the PRN, her pain was a 5. During speaking with the counselor, they spoke of depression symptoms and that he would likely recommend medications. Resident requested that she have time to research the medication that he recommends before starting, counselor agreed. After completion of session, received counselor's recommendation to add Venlafaxine to medication regimen. Resident notified and states she will begin to research the medication. [Medical Director] made aware of recommendation, awaiting response. Resident with no [signs or symptoms] of distress this morning, sleeping in bed. 4. Record review of the Assessment History Pain-Assessment report, dated 03/25/26, reflected 60 residents were assessed for pain on 03/24/26. 10 residents complained of low to moderate pain and were provided interventions. 5. Record review of the Narcotic Card Count Sheet audit forms completed on 03/24/26, reflected a medication audit was completed for every narcotic pain medication. 11 medications were re-ordered to ensure a 7 day supply were in the facility. 6. Record review of the pharmacy receipts, dated 03/24/26 and 03/25/26, reflected 11 medications were received from the pharmacy. 7. Record review of the Triplicate/Refill Request form, reflected blanks for the following items: medication requested/refilled, strength, amount, directions, name of physician notified for triplicate request, designated agent calling in to refill to pharmacy, pharmacy name/number to fax, pharmacy name/address to mail, last fill date, staff member requesting the triplicate/refill, date medication received in facility, and staff member verifying medication in facility. 8. During an interview on 03/25/26 at 1:30 p.m., the ADON said she was provided with an in-service education on administering pain medications to residents with signs and symptoms of pain to include monitoring for effectiveness of PRN medications, medication re-ordering, and medications not on hand. She said a 10 day supply of medication should be maintained on the carts for narcotic pain medication. She stated a triplicate request form will now be filled out for each medication requested and will be filled out and monitored by the ADON or DON. She verbalized if a medication was not on hand or in the emergency kit, then it would be sent by the pharmacy immediately. She stated she was provided with in-service education on the pain management policy (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	to include signs and symptoms of verbal and non-verbal pain. She said examples included: change in behaviors such as crying, groaning, or facial grimacing. She said pain was what the patient said it was and should be treated. She stated she was provided education on notification of change of condition policy to include notifying the doctor immediately of any new or increased pain. She said failure to provide pain medication could have been considered neglect. The ADON stated controlled pain medications must be documented and reconciled on both the MAR and count sheet. She said the count sheets were to be monitored and counted daily for discrepancies. 9. During an interview on 03/25/26 at 1:56 p.m., the DON stated she was provided with an in-service education on administering pain medications to residents with signs and symptoms of pain to include monitoring for effectiveness of PRN medications, medication re-ordering, and medications not on hand. She said a 10 day supply of medication should be maintained on the carts for narcotic pain medication. She stated a triplicate request form will now be filled out for each medication requested and will be filled out and monitored by the ADON or DON. She verbalized if a medication was not on hand or in the emergency kit, then it would be sent by the pharmacy immediately. She stated she was provided with in-service education on the pain management policy to include signs and symptoms of verbal and non-verbal pain. She said examples included: change in behaviors such as crying, groaning, or facial grimacing. She said pain was what the patient said it was and should be treated. She stated she was provided education on notification of change of condition policy to include notifying the doctor immediately of any new or increased pain. She said failure to provide pain medication could have been considered neglect. The ADON stated controlled pain medications must be documented and reconciled on both the MAR and count sheet. She said the count sheets were to be monitored and counted daily for discrepancies. 10. Record review of the in-service forms, dated 03/24/26, reflected the following one-on-one in-service education was provided to the ADON, DON, and the Administrator:*Administering pain medication for resident with signs and symptoms of pain*Pain management policy*Notification of change of condition policy*Abuse and Neglect policy*Controlled Medication Administration policy 10. Record review of the in-service forms, dated 03/24/26, reflected the following in-service education was provided to the nursing staff:*Administering pain medication for resident with signs and symptoms of pain. There were 11 nurses' signatures.*Pain management policy. There were 16 nurses' signatures.*Notification of change of condition policy. There were 15 nurses' signatures.*Abuse and Neglect policy. There were 16 nurses' signatures.*Controlled Medication Administration policy. There were 11 nurses' signatures. 11. During an interview on 03/25/26 between 1:20 p.m. and 2:06 p.m., LVN C, LVN D, LVN K, LVN M, MDS Coordinator L, and MDS Coordinator O stated they were provided with an in-service education on administering pain medications to residents with signs and symptoms of pain to include monitoring for effectiveness of PRN medication re-ordering, and medications not on hand. The nurses stated a triplicate request form will now be filled out for each medication requested and will be filled out and monitored by the ADON or DON. They verbalized that any pain medication not available at the facility could be obtained by the pharmacy even during weekends. They were able to verbalize non-verbal indicators of pain or discomfort to include change in behaviors such as crying, groaning, or facial grimacing. All staff stated pain was what the patient said it was and should be treated. The nurses said the doctor was to be immediately notified of any new or increased pain. They verbalized any failure to provide pain medication could have been considered neglect. The nurses stated controlled pain medications must be documented and reconciled on both the MAR and count sheet. She said the count sheets were to be monitored and counted daily for discrepancies. 12. Record review of the off cycle quality assurance meeting, dated 03/24/26, reflected the plan of removal was discussed with the interdisciplinary team to include the Medical Director, and 10 other team members. 13. During an interview on 03/25/26 at 2:12 p.m., the Medical Director stated he was notified of the immediate jeopardy and the plan of removal. The Administrator was informed the IJ was removed on 03/25/26 at 2:34 p.m. The facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm

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	675177	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	2711 Pine Tree Rd Longview, TX 75604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, and dispensing of all drugs and biologicals to meet the needs of each resident for 1 of 13 (Resident #49) residents reviewed for pharmacy services. 1. The facility failed to ensure Resident #49 received her scheduled oxycodone (narcotic pain medication) on 10/21/25, 11/03/25, 11/13/25, 11/23/25, and 03/23/26. 2. The facility failed to ensure Resident #49's oxycodone was re-ordered timely to prevent missed doses on 11/03/25, 11/13/25, and 03/23/26. 3. The facility failed to ensure a system was in place for medication reconciliation of narcotic medications and count sheets. 4. The facility failed to recognize and prevent Resident #49's oxycodone (narcotic pain medication) from discrepancies on the Individual Control Drug Record form, on 12/24/25 and 03/14/26. 5. The facility failed to recognize and prevent Resident #49's Tylenol #4 (narcotic pain medication) from discrepancies on the Individual Control Drug Record form on 12/28/25, 02/12/26, and 03/21/26. An immediate jeopardy (IJ) was identified on 03/24/26 at 4:10 p.m. The IJ template was provided to the facility on [DATE] at 4:27 p.m. While the IJ was removed on 03/25/26 at 2:34 p.m., the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all nursing staff had not been provided education on pain management, notification of changes of condition, abuse, neglect, and medication administration policy. This failure could place residents at serious risk for decreased quality of life, increased in severe, uncontrolled pain, misappropriation of physician ordered medications, serious harm, injury, impairment, or death. The findings included: Record review of the face sheet, dated 03/24/26, reflected Resident #49 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of morbid (severe) obesity due to excess calories, opioid dependence with withdrawal (dependence on narcotic pain medication), and chronic pain. Record review of the admission MDS assessment, dated 10/07/25, reflected Resident #49 had clear speech, was understood, and was able to understand others. Resident #49 had a BIMS score of 14, which reflected no cognitive impairment. Resident #49 had no behaviors or refusal of care during the look-back period. Resident #49 received PRN pain medication and had occasional pain during the 5 day-look back period. The MDS reflected Resident #49 received opioid pain medication. Record review of the comprehensive care plan, dated 10/06/25, reflected Resident #49 had the potential for uncontrolled pain. Resident #49's pain goal was 0. The interventions included: anticipating the need for pain relief and responding immediately to any complaints of pain, evaluating the effectiveness of pain interventions, monitor/document for side effects of pain medication, and monitor/record/report non-verbal signs or symptoms of pain. Record review of Resident #49's order summary report, dated 03/24/26, reflected the following orders:1. Acetaminophen-Codeine 300-60 mg (Tylenol #4) - give 1 tablet by mouth every 8 hours as needed for pain, which was ordered on 12/24/25.2. oxycodone-Acetaminophen 10-325 mg - Give 1 tablet by mouth three times a day for moderate to severe pain, which was ordered on 10/07/25. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 10/14/25 reflected the following:1. An incorrect date of 10/17/25 was placed on the 6 a.m. dose administered on 10/20/25.2. The 6 a.m. dose given on 10/21/25 was filled out and then marked out as not given. Record review of Pain SBAR, dated 10/20/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was to her lower back. The pain was described as aching and throbbing. She stated the pain was daily, but not constant and lasted 30 - 60 minutes. She stated medications helped relieve the pain. The Medical Director was notified on 10/20/25 at 3 p.m. with no new orders given. Record review of the Pain SBAR, dated 10/27/25, reflected Resident #49 had at least one episode of pain that was a 10 or it was described (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	as very severe/horrible. The pain was to her lower back. The pain was described as aching and throbbing. She stated the pain was constant and lasted 30 - 60 minutes. She stated medications helped relieve the pain. The Medical Director was notified on 10/27/25 at 6 p.m. with no new orders given. Record review of Resident #49's MAR, dated October 2025, reflected the following:1. On 10/21/25 the 6 a.m. dose of oxycodone was signed out as given, which did not match the Individual Control Drug Record form. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 10/22/25, reflected the following:1. A dose of oxycodone-acetaminophen was administered at 5:30 a.m. on 11/03/25 and was the last pill on that card of medication. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 11/03/25, reflected the following:1. The card of medication was received on 11/03/25 at 2:15 p.m. and had 30 pills. The first dose of oxycodone-acetaminophen was administered at 10 p.m. on 11/03/25. Resident #49 missed her 2 p.m. dose.2. A dose of oxycodone-acetaminophen was administered at 2 p.m. on 11/13/25 and was the last pill on that card of medication. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 11/14/25, reflected the following:1. The card of medication was received on 11/14/25 and had 30 pills. The first dose of oxycodone-acetaminophen was administered at 6 a.m. on 11/14/25. Resident #49 missed her 10 p.m. dose on 11/13/25.2. On 11/23/25, Resident #49's 6 a.m. dose was not signed out as given. Record review of the Pain SBAR, dated 11/22/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was generalized and was described as dull, throbbing, tingling. The frequency of pain was less than daily and lasted 30 - 60 minutes. The pain affected sleep, appetite, physical activity, relationships, emotions, and concentration. She stated medications helped relieve the pain. The Medical Director was notified on 11/22/25 at 11:00 a.m. with orders to continue current medications. Record review of the Pain SBAR, dated 11/30/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was to her right lower leg/foot, left lower leg/foot, and generalized. She described the pain as aching, throbbing, burning, and tingling. The frequency of the pain was daily, but not constant and lasted 1 - 2 hours. She stated the pain was affected by increased sadness and emotions. She said the pain affected her sleep, appetite, physical activity, emotions, and concentration. She stated medications helped relieve the pain. The Medical Director was notified on 12/01/25 at 12:00 a.m. (midnight) with no new orders. Record review of Resident #49's MAR, dated November 2025, reflected the following:1. On 11/03/25 the 2 p.m. dose of oxycodone-acetaminophen was not given because medication was unavailable.2. On 11/13/25 the 10 p.m. dose of oxycodone-acetaminophen was not given because the medication was unavailable.3. On 11/23/25 all three doses of oxycodone-acetaminophen were signed out as given, which did not match the Individual Control Drug Record form.3. On 11/26/25 the 6 a.m. dose of oxycodone-acetaminophen was not given because Other/see nurses note. Record review of the nursing progress notes, dated 11/21/25 to 12/22/25, reflected no nursing notes were dated for 11/26/25. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 11/23/25, reflected the following:1. An incorrect date of 12/03/25 was placed on the 6 a.m. dose administered on 12/04/25.2. An incorrect date of 12/09/25 was placed on the 10 p.m. dose administered on 12/08/25.3. The last pill was signed out as given on 12/24/25 at 6 a.m. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 12/24/25, reflected the following:1. The first pill of 90 was signed out as given on 12/24/25 at 6 a.m., which was the second dose of medication signed out for the same date and time.2. An incorrect date of 01/07/26 was placed on the 6 a.m. dose administered on 01/08/26. Record review of Resident #49's Individual Control Drug Record form for acetaminophen-codeine, dated 12/23/25, reflected the following:1. An incorrect date of 12/27/25 was placed on the 2:20 a.m. dose administered on 12/28/25.2. The 6 p.m. dose on 12/28/25 was filled out and then marked out as not given. There was no explanation for the mark through by LVN H. The 6 (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	p.m. dose was immediately signed out again on the next line, but the count continued and 1 pill was unaccounted for. Record review of the Pain SBAR, dated 12/27/25, reflected Resident #49 had almost constant or frequent pain level of 5 - 9 moderate to severe pain on the 1 - 10 pain scale. The pain was to her right and left lower leg/foot. The pain was described as throbbing, burning, tingling, sharp, shooting. The frequency of pain was daily, but not constant and lasted 1 - 2 hours. She said the pain affected her sleep, emotions, and concentration. She said the pain was relieved with medications. The Medical Director was notified on 12/27/25 at 12 a.m. (midnight) with no new orders. Record review of Resident #49's MAR, dated December 2025, reflected no doses of oxycodone-acetaminophen were missed. There were zero doses of acetaminophen-codeine signed out as given on the MAR, which did not match the Individual Control Drug Record form. Record review of Resident #49's Individual Control Drug Record form for acetaminophen-codeine, dated 01/01/26, reflected the following:1. An incorrect date of 01/04/26 was placed on the 2 a.m. dose administered on 01/05/26.2. An incorrect date of 01/07/26 was placed on the 2 a.m. dose administered on 01/08/26. Record review of Resident #49's Individual Control Drug Record form for acetaminophen-codeine, dated 01/23/26, reflected the following:1. An incorrect date of 01/25/26 was placed on the 2 a.m. dose administered on 01/26/26. Record review of Resident #49's MAR, dated January 2026, reflected no doses of oxycodone-acetaminophen were missed. The MAR reflected Resident #49's acetaminophen-codeine 300-60 mg was given 10 times for the month, which did not match the Individual Control Drug Record form. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 01/23/26, reflected the following:1. An incorrect date of 02/12/26 was placed on the 10 p.m. dose administered on 02/11/26.2. An incorrect date of 02/20/26 was placed on the 6 a.m. dose administered on 02/21/26. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 02/03/26, reflected the following:1. An incorrect date of 02/09/26 was placed on the 2 a.m. dose administered on 02/10/26.2. The last pill was signed out as given on 02/12/26 at 6 p.m. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 02/11/26, reflected the following:1. The first pill of 30 was signed out as given on 02/12/26 at 6 p.m., which was the second dose of medication signed out for the same date and time.2. An incorrect date of 02/15/26 was placed on the 2 a.m. dose administered on 02/16/26.3. An incorrect date of 02/21/26 was placed on the 2 a.m. dose administered on 02/22/26. Record review of Resident #49's MAR, dated February 2026, reflected the 10 p.m. dose of Resident #49's oxycodone on 02/08/26 was not signed out as given. The MAR reflected Resident #49's acetaminophen-codeine was only given 4 times during February, which did not match the Individual Control Drug Record form. Record review of Resident #49's Individual Control Drug Record form for acetaminophen-codeine, dated 02/24/26, reflected the following:1. An incorrect date of 03/07/26 was placed on the 10 a.m. dose administered on 03/06/26.2. An incorrect date of 03/07/26 was placed on the 6 p.m. dose administered on 03/06/26.3. An incorrect date of 03/08/26 was placed on the 2 a.m. dose administered on 03/09/26.4. An incorrect date of 03/09/26 was placed on the 2 a.m. dose administered on 03/10/26.5. An incorrect date of 03/18/26 was placed on the 2 a.m. dose administered on 03/19/26.6. An incorrect date of 03/19/26 was placed on the 2 a.m. dose administered on 03/20/26.7. The 6 p.m. dose on 03/21/26 was filled out and then marked out as not given. There was no explanation for the mark through LVN H. The 6 p.m. dose was immediately signed out again on the next line, but the count continued and 1 pill was unaccounted for. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 02/21/26, reflected the following:1. An incorrect date of 03/05/26 was placed on the 10 p.m. dose administered on 03/04/26.2. An incorrect date of 03/08/26 was placed on the 6 a.m. dose administered on 03/09/26.3. On 03/14/26, three extra doses of medication were signed out at 7 a.m., 3:09 p.m., and 5:40 p.m.4. The last dose of medication was given on 03/22/26 at 10 p.m. Record review of Resident #49's Individual Control Drug Record form for oxycodone-acetaminophen, dated 03/23/26, reflected the following:1. The first pill of 90 was given on 03/23/26 at 3 p.m. when the medication arrived. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #49 missed the 6 a.m. dose on 03/23/26. Record review of Resident #49's MAR, dated March 2026, reflected the following:1. On 03/05/26, Resident #49's 6 a.m. dose of oxycodone-acetaminophen was not given because she was sleeping. 2. On 03/23/26, Resident #49's 6 a.m. dose of oxycodone-acetaminophen was not given because Other/see nurses note.The MAR reflected Resident #49's acetaminophen-codeine was given only 3 times, which did not match the Individual Control Drug Record form. Record review of the nursing progress notes, dated 02/22/26 to 03/25/26, reflected on 03/23/26 LVN H documented While awaiting pharmacy to deliver [resident] oxycodone, may give [resident] Tylenol #4 as a replacement to ensure [resident] is not in any pain per [doctor]. During an observation and interview on 03/23/26 beginning at 2:32 p.m., Resident #49 was lying in her bed with the head of her bed elevated slightly. She had a family member in the room during the interview. Resident #49 reported she had not received her scheduled pain medications on several different occasions since she was admitted to the facility. Resident #49 said there was not a place on her body that did not hurt. She said she depended on and needed her pain medication to keep the pain controlled. She said the pharmacy the facility used was in another city and the medications were not readily available. Resident #49 started sobbing. She said she was waiting for her medication that was due at 2 p.m. and had been in pain since this morning. She stated she received a lower level pain pill at 6 a.m. that worked for a short time but had completely worn off during the interview. She stated her pain currently was 10 out of 10 on the pain scale. She said she would never kill herself, but she begged God to take her. She said her pain was exacerbated every time she missed her scheduled pain medication. She said her pain was tolerable at a 4 or 5 on the pain scale. She reported her pain was well-controlled when she received her pain medications as prescribed. Resident #49 stated she felt the facility did not understand her pain and did not try to accommodate her pain needs. She said she was constantly checking with the nurses to ensure she had enough pain medication and would not run out. She said when she runs out of pain medication she becomes frantic and thinks to herself not again, please, not again. During the interview at 3:04 p.m. LVN H knocked, entered Resident #49's room and reported that her pain medication had arrived at the facility and she was going to bring the pill to her. Resident #49 cried with relief that her pain medication was at the facility. During an interview on 03/24/26 beginning at 7:23 a.m., LVN K said Resident #49 complained of pain constantly and took her scheduled and PRN pain medication regularly. She said her pain level was anywhere from 1-10 on the 1-10 pain scale. LVN K stated she had asked the doctor to schedule her PRN pain medication, but he did not want to schedule them. LVN K was unsure if Resident #49 saw a pain management doctor. LVN K stated she was aware two times Resident #49 had run out of her scheduled pain medication but was unaware if Resident #49 had any increased pain. LVN K stated pain was what the patient stated it was. She said Resident #49 needed her pain medications because she constantly hurt. She said she should not have run out of her pain medications, but they frequently ran out of medications before the pharmacy delivered them. She said the doctor or an agent of the doctor had to call the narcotic medications in or re-order them. She said the only agent at the facility she was aware of was the ADON. LVN K said when she noticed the narcotic pain medication was running low, she clicked re-order in the electronic charting system, which sends an alert to the pharmacy. She said after that, she called the ADON, who called the pharmacy for refills. She said if there were no refills left; the doctor had to send a new triplicate to the pharmacy. LVN K stated this process was usually completed timely, but the pharmacy did not deliver medications timely. She said the pharmacy was in another city, which was a couple hours away. LVN K said there was really no system for following up with the pharmacy after the medication had been ordered. LVN K said schedule II narcotics like oxycodone were not kept in the emergency medication kit provided by the pharmacy. During an interview on 03/24/26 beginning at 9:32 a.m., the ADON stated the nurses were responsible for re-ordering narcotic pain medications. She said during the medication pass, if they noticed a medication was getting low, the nurses could go into the electronic charting system and click re-order for the medications that were needed and it would have sent an alert to the pharmacy. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She stated if the pain medication had no refills left, then she would have called the pharmacy for approval. She said if a new triplicate was needed, then the doctor had to directly send that to the pharmacy. The ADON stated the doctor usually sent the triplicate for pain medication directly to the pharmacy without any issues. She said if pain medication did run out, the facility had an emergency kit, which had pain medications in it. She said the emergency kit did not have scheduled II medications like oxycodone. She said she was unaware of any residents who had run out of scheduled pain medication. She stated Resident #49's oxycodone had been re-ordered on 03/20/26 but the delivery drivers' car had broken down on the way. During an interview on 03/24/26 beginning at 12:16 p.m., LVN H stated she did not normally have issues with receiving medication from the pharmacy. LVN H said Resident #49 had run out of scheduled pain medication at least twice that she was aware. LVN H stated if the pharmacy did not get the electronic prescription from the doctor by Friday, then the medication would not have been sent until Monday. LVN H stated Resident #49 received scheduled pain medication three times a day. She said if the nurses waited until the medication card was in the blue (8 pills left) to re-order her medication, then she would not have had enough to last the weekend. LVN H stated she worked on 03/21/26 and realized Resident #49 was not going to have enough medication to last the weekend. LVN H stated she called the pharmacy several times over the weekend, but the pharmacy did not deliver medications on the weekend. She said the medication was supposed to have come in earlier on 03/23/26 but the delivery driver had car trouble. LVN H stated Resident #49 was obsessed with her pain medication. She stated Resident #49 had chronic pain and she received her scheduled and PRN pain medications around the clock to keep her pain under control. She said when Resident #49 did not receive her pain medication, her pain became out of control and took a while to get back under control. She said on 03/23/26 she obtained an order for acetaminophen-codeine 300-60 mg x 1 dose to give in place of her missed oxycodone. She stated Resident #49 reported the pill was effective. She said as soon as Resident #49's oxycodone arrived from the pharmacy, she administered it. LVN H stated there were no set days to re-order medication, but the medications were re-ordered as it was noticed they were getting low. During an interview on 03/24/26 beginning at 1:09 p.m., the DON stated there was no system in place for reviewing or monitoring the Individual Controlled Drug Record forms. She said when the last medication was given off the medication card, the Individual Controlled Drug Record forms were given to medical records to file. The DON stated she did not review the forms for discrepancies or errors. She said she expected the nurses to sign out narcotic pain medications as they were given. She said if an error occurred on the narcotic count sheet or a staff member dropped a pill, she expected the reason it was marked out indicated on the count sheet. She stated she expected 2 nurse signatures if the medication was wasted. She said it was important to ensure the narcotic control records were accurate to prevent drug discrepancies, which placed the resident at risk for a drug diversion or medication errors. The DON stated she was aware that Resident #49 had run out of medication on 03/23/26. She said the facility attempted to get the medication STAT 'ed but the driver had car trouble. She said she was unaware Resident #49 was having severe, uncontrolled pain because she had missed her pain medication. She was unaware of any other times Resident #49 had gone without her pain medication. The DON stated any missed dose of pain medication would have made it harder to maintain her desired pain level. She stated pain was what the resident said it was. She said pain was monitored every shift and when any pain medication was administered. The DON stated this was documented on the MAR. She stated severe or uncontrolled pain should have been reported to the doctor. The DON stated when the nurses were passing medications and the medications were getting low; they should have marked re-order in the electronic charting system. She stated the recommended re-order time was when the medication had approximately 8 pills left. She said marking re-order in the electronic charting system, sent the order directly to the pharmacy. She stated the cut off time for re-ordering medications was 6 p.m., so she expected staff to ensure ordering was completed before 6 p.m. She said no medications were delivered on the weekend, unless they were ordered STAT and the (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	facility paid a fee. She said if the medication required a triplicate, the nurses should have notified the Medical Director so he could send the triplicate to the pharmacy. The DON stated the Medical Director did not send Resident #49's triplicate to the pharmacy until 8 or 9 p.m. on 03/20/26, which was past the cut off time, so it was not scheduled for delivery until 03/23/26. She said it was important to ensure medications were ordered timely, so they did not run into issues with medications running out. During an interview on 03/24/26 beginning at 1:31 p.m., the Administrator stated she expected pain was what the patient said it was. She stated she expected resident's pain to be controlled and kept under control. She said the nurses were responsible for monitoring to ensure resident's pain was kept under control. She said she expected the nurses to monitor the resident's pain at least every shift. She said she expected the nurses to ensure severe or uncontrolled pain was reported to the doctor immediately. She said the ADON and DON were responsible for monitoring the nurses. The Administrator stated it was important to ensure pain was kept under control to maintain a resident's pain at a lower level. She said once a resident's pain becomes severe, it was harder to get it back under control. The Administrator was unsure if the DON had a system in place for monitoring narcotic count sheets or medication reconciliation. The Administrator stated she expected narcotic pain medications to be reconciled and given the way they were ordered. She stated she expected the narcotic pain medications to have been counted each shift and notify the DON of any discrepancies. She said if discrepancies were identified an investigation should have been conducted. She said it was important to ensure medication reconciliation was accurate to prevent medication errors or drug diversion. She said the nurses should have been reviewing the narcotic count sheets for discrepancies, each time a medication was given or during shift change. During an interview on 03/24/26 beginning at 2:00 p.m., the Medical Director stated when a medication that required a triplicate was running low, the facility notified him by telephone or fax. He said he liked the facility to send the request at least 24 hours in advance, so he had time to complete the request. The Medical Director stated the facility was pretty good about letting him know ahead of time but there have been a few instances where he was not notified timely. He was unsure of any incidents recently with Resident #49. He believed the facility did not have a systemic issue. The Medical Director stated he had sent a triplicate for Resident #49 within the last week but was unsure if she went without any medication. The Medical Director stated he was unaware Resident #49 had been in severe, uncontrolled pain. He said he would like to have been notified if a resident's pain medication were unavailable. He said he could have found alternate ways to obtain the medications even during the weekend. The Medical Director stated it was important to ensure pain medication was given as ordered to prevent an increase in pain symptoms. He stated it was important to maintain resident's pain at a comfortable level and pain was what the patient said it was. During an interview on 03/24/26 beginning at 2:12 p.m., the policy for medication reconciliation and pharmacy services were requested from the Regional Compliance Nurse. She said the facility did not have a general policy for pharmacy services. She provided the following policies. Record review of the Medication Orders policy, dated 2025, reflected Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the current physician order sheet, the telephone order sheet, if it is a verbal order, and the MAR. Record review of the Receiving Medication from Pharmacy policy, dated 2025, reflected Medications and related products are received form the pharmacy supplier on a timely basis. The facility maintains accurate records of medications ordered and receipt of. The policy did not address pharmacy services of receiving or dispensing medication. The Administrator was notified on 03/24/26 at 4:25 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided with the Immediate Jeopardy template on 03/24/26 at 4:27 p.m. and a plan of removal was requested. The following plan of removal was submitted by the facility and accepted on 03/25/26 at 11:12 a.m. and included the following: Interventions:Resident #49 was assessed for pain by the ADON. The [Medical Director] was notified. No complaints of pain or additional issues noted. Resident #49 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	2711 Pine Tree Rd Longview, TX 75604

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	has pain medication ordered and in facility. No new or worsening pain nor emotional stress at this time. Completion date 03/24/26.All residents in the facility were assessed for any increased pain by the DON and Charge Nurses as of 03/24/26. No additional residents with new or uncontrolled pain were identified. Completion date 03/24/26.A narcotic count/MAR reconciliation was completed by the DON/ADON/Regional Compliance nurse, and all discrepancies were addressed through the medication error process. Residents that receive narcotic medications were audited by the DON/ADON/Regional Compliance Nurse to ensure that at least a 7 day supply are available on the medication carts. All residents have the appropriate amount of medications available as of 03/24/26. Completion date 03/24/26.The DON/ADON/or designee will be responsible for counting all narcotic medications daily to ensure at least a 7 day supply is available on the medication carts and reviewing for discrepancies to ensure accuracy of narcotic count sheets before being filed in medical records. Completion 03/24/26.The DON/ADON/or designee will be responsible for calling the physician when a 10 day supply of medication is on the cart to obtain the triplicates needed to reorder narcotic medications to ensure a 7 day supply is available. A triplicate/refill request form will be completed and available for review to ensure staff know that medications have been reordered. DON/ADON/or designee will review form daily until medication is delivered and marked as received. Completion 03/24/26. The DON/ADON/designee will monitor the refill process for all medications including the weekends. Medications are available in the ekit, if unavailable, medications can be stat (immediately) delivered from the pharmacy or called to a local pharmacy.In-services: The Compliance Nurse will in-service the Administrator/DON/ADON 1:1 (one on one) on the following topics on 03/24/26.1. Administering pain medication for residents with signs and symptoms of pain.2. Pain management Policy -Signs and symptoms of pain verbally and non-verbal. (Change in behaviors such as crying, whining, groaning, facial expressions, grimacing, frowning, protecting body movements, guarding, or clutching)3. Notification of a Change of Condition Policy- to the charge nurse or physician immediately including signs and symptoms of increased pain. 4. Abuse and Neglect Policy - to include failure to administer pain medications could be considered neglect.5. Medication Administration Policy- to include controlled medications, medication reconciliation, and documentation both on the MAR and count sheet.All charge nurses and medication aides were in-serviced on 03/24/26 by the Compliance Nurse/DON/ADON regarding the following topics below. All charge nurses, including agency staff, new hires and PRN charge nurses not in-serviced by 03/24/26 will not be allowed to work in their assigned position until completion of these in-services: Completion as of 03/25/26 DON and ADON were in-service by Compliance Nurse.1. Administering pain medication for residents with signs and symptoms of pain.2. Pain management Policy -Signs and symptoms of pain verbally and non-verbal. (Change in behaviors such as crying, whining, groaning, facial expressions, grimacing, frowning, protecting body movements, guarding, or clutching)3. Notification of a Change of Condition Policy- to the charge nurse or physician immediately including signs and symptoms of increased pain. 4. Abuse and Neglect Policy - to include failure to administer pain medications could be considered neglect.5. Medication Administration Policy- to include controlled medications, medication reconciliation, and documentation both on the MAR and count sheet.The medical director was notified on 03/24/26 on the immediate jeopardy situation by the Administrator.An AD HOC QAPI meeting was held on 03/24/26 by the Interdisciplinary Team to discuss the immediate jeopardy and review the plan of removal for pain. The Administrator and DON will implement this written Plan of Removal and will continue to monitor completion and compliance of this written Plan of Removal. On 03/25/26 the surveyor confirmed the facility implemented their plan

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Residents #33 and #58) reviewed for infection control practices during medication pass. 1. The facility failed to ensure LVN C performed hand hygiene before or after passing medication to Resident #58, before checking Resident #33's blood sugar and administering insulin, and after leaving Resident #33's room on 03/24/26. 2. The facility failed to ensure LVN C sanitized the blood glucometer machine before and after checking Resident #33's blood sugar. 3. The facility failed to ensure LVN C sanitized the top of the insulin vial before drawing up Resident #33's insulin. This failure could place residents and staff at risk for cross contamination and the spread of infection.The findings included: 1. Record review of the face sheet, dated 03/25/26, reflected Resident #58 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), type 2 diabetes (high blood sugar), and morbid (severe) obesity due to excess calories. Record review of the quarterly MDS assessment, dated 02/03/26, reflected Resident #58 had clear speech, was understood, and was able to understand others. Resident #58 had a BIMS score of 15, which indicated no cognitive impairment. She had no behaviors or refusal of care. Record review of the comprehensive care plan, last reviewed 03/06/26, reflected Resident #58 had diabetes (high blood sugar), received diuretic (medication for edema (swelling)) therapy, had liver disease related to cirrhosis (scarring or inflammation of the liver), had hypertension (high blood pressure), received antiplatelet medication (blood thinner), had a mood problem, received anti-anxiety medications, received anti-depressant medication, and potential for uncontrolled pain. The interventions included: administer medication per orders. Record review of Resident #58's order summary report, dated 03/25/26, reflected the following orders:1. Advair Diskus 250 MCG/ACT - 1 puff inhale orally two times a day for wheezing, which was ordered on 11/15/23.2. Aspirin 81 mg chewable - Give 1 tablet by mouth one time a day for blood thinner, which was ordered on 04/14/25.3. Carafate 1 GM - Give 1 tablet by mouth two times a day for gastroesophageal reflux disease, which was ordered on 07/03/25.4. Famotidine 20 mg - Give 1 tablet by mouth two times a day for gastroesophageal reflux disease, which was ordered on 10/13/24.5. Fluticasone Propionate nasal suspension 50 MCG/ACT - Give 2 sprays in both nostrils one time a day for other allergic rhinitis (immune response which causes sneezing, nasal congestion, itchy, and runny nose), which was ordered on 11/15/23.6. glipizide 5 mg - Give 1 tablet by mouth two times a day for type 2 diabetes, which was ordered on 03/26/24.7. Lactulose 10 GM/15 mL - Give 30 mL by mouth two times a day for cirrhosis of liver, which was ordered on 01/25/26.8. Multivitamin - Give 1 tablet by mouth one time a day for vitamin deficiency, which was ordered on 04/14/25.9. Potassium Chloride ER 10 MEQ - Give 1 tablet by mouth two times a day for hypokalemia (low potassium level), which was ordered on 05/22/25.10. Protonix DR 40 mg - Give 1 tablet by mouth once a day for gastroesophageal reflux disease, which was ordered on 12/17/25.11. venlafaxine 75 mg - Give 1 tablet by mouth two times a day for depression, which was ordered on 01/09/26. Record review of Resident #58's MAR, dated March 2026, reflected Advair Diskus, aspirin, Carafate, famotidine, fluticasone propionate nasal spray, glipizide, lactulose, multivitamin, potassium chloride, Protonix, and venlafaxine were given in the morning on 03/24/26 by LVN C. 2. Record review of the face sheet, dated 03/25/26, reflected Resident #33 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of type 2 diabetes (high blood sugar). Record review of the quarterly MDS assessment, dated 02/09/26, reflected Resident #33 had clear speech, was understood, and was able to understand others. Resident #33's BIMS score was 15, which indicated no cognitive impairment. She had no behaviors or refusal of care. Resident #33 received insulin (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	injections 7 out of 7 days during the look back period and had 2 insulin order changes. Record review of the comprehensive care plan, last reviewed 02/18/2026, reflected Resident #33 had diabetes (high blood sugar). The interventions included: medications as ordered and fasting blood sugar as ordered. Record review of Resident #33's order summary report, dated 03/25/26, reflected the following orders:1. Novolin 70/30 subcutaneous suspension 100 unit/mL - inject 20 units subcutaneously one time a day related to diabetes, which was ordered on 02/05/26. Record review of the MAR, dated March 2026, reflected Resident #33's blood sugar was 148 and 20 units of Novolin 70/30 was given on 03/24/26 in the morning by LVN C. During an observation on 03/24/26 between 6:52 a.m. and 7:01 a.m., the following occurred during medication pass:1. LVN C did not perform hand hygiene before or after administering Resident #58's medication.2. LVN C did not perform hand hygiene before or after checking Resident #33's blood sugar.3. LVN C did not sanitize the glucometer (machine used to check blood sugars) before or after checking Resident #33's blood sugar.4. LVN C did not sanitize the top of the insulin (blood sugar medication) vial before using the insulin needle to draw up 20 units of medication.5. LVN C did not perform hand hygiene before or after administering Resident #33's insulin. During an interview on 03/25/26 at 3:02 p.m., LVN C stated hand hygiene should have been performed before and after passing medications, before and after checking blood sugar, and before and after giving insulin. LVN C stated the blood glucose machine should have been sanitized before and after checking blood sugar. LVN C stated the insulin vial should have been cleaned prior to drawing up the insulin. LVN C stated she was nervous with the state surveyor watching and just forgot to use hand sanitizer, clean the glucometer, and clean the top of the insulin vial. LVN C stated failing to follow the infection control practices during medication administrations could have led to cross contamination or the spread of infection. During an interview on 03/25/26 at 3:39 p.m., the DON stated she expected the nurses to follow the infection control practices during medication administration. The DON stated she expected the nurses to perform hand hygiene before and after medication administration, sanitize the blood glucometer before and after use, and clean the insulin vial before drawing up insulin. The DON stated the pharmacy consultant was responsible for monitoring to ensure infection control practices were followed during medication administration. The DON stated the pharmacy consultant had not identified any issues with infection control during her visits. The DON stated it was important to ensure infection control practices were followed during medication administration to prevent the spread of infection or cross contamination. During an interview on 03/25/26 at 3:45 p.m., the Administrator stated she expected the nursing staff to ensure hand hygiene was performed before and after medication administration, before and after checking blood sugar, and before and after giving an insulin injection. The Administrator stated she expected the blood glucose machine to be sanitized before and after checking blood sugar. She stated she expected the top of the insulin vial to be cleaned before drawing up the insulin. The Administrator stated the ADON or DON were responsible for monitoring to ensure infection control practices were followed during the medication pass. She stated it was important to ensure infection control practices were followed to prevent the spread of infection. Record review of the Fundamental of Infection Control Precautions policy, undated, reflected Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situation that require hand hygiene: . Before and after direct patient care. Before and after performing any invasive procedure (e.g., fingerstick blood sampling) . Record review of the Glucometer policy, undated, reflected .clean and inspect meter exterior with each use. Meter will be cleaned with a germicidal and allowed to air dry between patient testing. Record review of the Novolin 70/30 insulin manufacturer instructions, revised November 2022, reflected .wipe the rubber stopper with an alcohol swab.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to be treated with respect and dignity for 1 of 1 residents reviewed for resident rights. (Resident #1)The facility failed to ensure Resident #1's catheter bag had a privacy cover in place.This failure could cause residents to feel embarrassed and lower their quality of life.Findings included:Record review of Resident #1's face sheet, dated 12/17/25, indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included Urinary Tract Infection (a bacterial infection in the urinary system, commonly causing burning pain during urination, frequent urges to pee, and cloudy or bloody urine),.Record review of Resident #1's admission MDS, dated [DATE], indicated Resident #1 usually understood others and made himself understood. Resident #1 had a BIMS score of 11, which indicated his cognition was moderately impaired. The MDS revealed that Resident #1 used a catheter. Record review of Resident #1's comprehensive care plan, dated 12/17/25, indicated Resident #1 had an indwelling catheter. Indicated that Resident #1 would be free from catheter-related trauma.Record review of a physician's order dated 12/26/2025 shows that Resident #1 had an order that said, Ensure foley bag is in privacy bag while in bed or wheelchair.During an interview and observation on 3/23/26 at 9:30 a.m., Resident #1 had a catheter bag attached to the side of his bed. It could be observed from the entrance of the room. The catheter bag did not have a privacy cover on. Urine was observed inside his bag. Resident #1 said that it bothered him that his urine was visible to anyone that could walk by.During an observation on 3/24/26 at 12:22 p.m. Resident #1's catheter bag was seen from the hallway without a privacy cover on. During an interview on 3/25/26 at 10:03 a.m. CNA G said that it was the responsibility of CNAs and Nurses to ensure that privacy covers were on catheter bags. She said that if a resident did not have their privacy cover on it could be embarrassing to them.During an interview on 3/25/26 at 3:12 p.m. the Director of Nurses said that it was the responsibility of all nurses to ensue that residents who use a catheter bag have a privacy cover on that bag. She said that residents could potentially be embarrassed if their urine could be seen by anyone in the facility. She said she was unsure if there was a specific policy that stated residents required a privacy cover over their catheter bag.During an interview on 3/25/26 at 3:27 p.m. the Administrator said that Nurses and CNAs are responsible to ensure that privacy covers were placed on catheter bags. She said that residents could be placed at risk for embarrassment if their privacy cover was not on.Record review of an undated facility policy titled, Catheter Care revealed there was no information regarding a privacy cover.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 1 of 18 residents (Resident #40) reviewed for the physical environment. The facility failed to ensure Resident #40's room had adequate lighting. This failure could place residents at risk of falls, a decreased quality of life and an unsafe environment. The findings included: Record review of the face sheet, dated 3/24/26, reflected Resident #40 was a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of severe protein-calorie malnutrition, muscle wasting and atrophy(wasting due to lack of use or malnutrition), muscle weakness (generalized) and other abnormalities of gait and mobility, and other lack of coordination. Record review of the nursing home MDS assessment, dated 3/9/26, reflected Resident #40 had unclear speech, was usually understood by others, and was usually able to understand others. Resident #40 had a BIMS score of 4, which indicated severe cognitive impairment. Resident #40 usually required total assistance from staff with ADLs and was always incontinent of bowel and bladder. Record review of the comprehensive care plan, dated 2/21/26, reflected Resident #40 was at risk for falls. The interventions included: low bed, floor mat to bed side, anticipate and meet the resident's need, educate the resident, family, caregivers about safety reminders and what to do if a fall occurs. Record review of the fall incident report, dated 3/13/26, reflected Resident #40 had an unwitnessed fall in his room; no injuries sustained. Record review of the fall incident report, dated 3/16/26, reflected Resident #40 had an unwitnessed fall in his room; no injuries sustained. Record review of the fall incident report, dated 3/17/26, reflected Resident #40 had an unwitnessed fall in his room; no injuries sustained. During an observation on 3/23/26 at 10:38 A.M., Resident #40 was lying in bed watching T.V. with feeding running, with head of bed elevated. When the main light in resident's room was turned on it was not working. The room was very dark. During an observation and interview on 3/24/26 at 9:28 A.M., Resident #40 was lying in bed resting while feeding running. When the main light in resident's room was turned on it was very dim. Resident #40 said he did not like the room to be that dark. During an observation on 3/24/26 at 11:20 A.M., Resident #40 was lying in bed resting. When the main light in Resident #40's room was turned on it was very dim and the room was dark. During an observation on 3/25/26 at 9:02 A.M., Resident #40 was lying in bed resting while feeding running. Resident #40's main light in room continues to shine dim. During an interview on 3/25/26 at 2:13 P.M., CNA E stated she noticed the main light in Resident #40's room was very dim. She stated she notified the nurse yesterday about the dim light. She stated the Maintenance Supervisor was waiting on the bulbs. She stated he had ordered the bulbs, but they had not come in yet. She stated the negative effect of the dim light was it makes it hard to see in Resident #40's room. During an interview on 3/25/26 at 2:22 P.M., LVN D stated she had noticed the light in Resident #40 room. She stated she put in a maintenance note yesterday about the dim light. She stated maintenance was responsible for replacing the lights. She stated a negative effect of the light being dim was Resident #40 could not see, and it was dark in his room without the main light functioning properly. During an interview on 3/25/26 at 2:29 P.M., Maintenance Supervisor stated he was notified about the dim light in Resident #40 room yesterday. He stated he was dealing with the state inspection guy yesterday and he had another priority issue to fix. He stated he would fix the light in Resident #40's room next. He stated the negative effect on the dim light was it could affect Resident #40's vision for him to see adequately. During an interview on 3/25/26 at 2:33 P.M., the Assistant Director of Nursing stated she had not noticed the light in Resident #40's room. She stated maintenance was responsible for changing the light bulbs in the resident's room. She stated the negative effect was a more somber mood (feeling sadness or gloom) for Resident #40 and made the residents want to sleep more. During an interview on 3/25/26 at 3:54 P.M., the Director of Nursing stated the light should be available to (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents if they wanted them. She stated maintenance was responsible for ensuring the residents had efficient light in the rooms. She stated the negative effect was it could affect Resident' #40's sleep schedule, being in a dark room. During an interview on 3/25/26 at 4:10 P.M., the Administrator stated she expected the residents' rooms to be well lit. She stated everyone was responsible and especially the Maintenance Supervisor when he was aware. She stated staff should notify maintenance. She stated the negative of the dim light was that the resident could become depressed or trip and fall. Record review of the Resident Rights policy, undated, reflected The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 18 resident (Residents #30) reviewed for urinary incontinence. The facility failed to ensure staff assisted Resident #30 with using her pure wick system (urine collection system). This failure could place residents at risk for pain, urinary tract infections and a decreased quality of life. Findings included: Record review of Resident #30's face sheet dated 3/24/26 indicated a 65-years-old female admitted to the facility on [DATE]. Resident #30 had diagnoses including: morbid (severe) obesity with alveolar hypoventilation (a condition where severely obese individuals cannot breathe deeply), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side (a form of paralysis causing total or partial loss of muscle function) and unspecified fall. Record review of the comprehensive MDS dated [DATE] indicated Resident #30 had clear speech, understood others, and was understood by others. The MDS indicated she had a BIMS score of 14 indicating moderate cognitive impairment. Resident #30 required maximal assistance from staff for toileting hygiene and personal hygiene. The MDS indicated Resident #30 was always incontinent of bladder and continent of bowel. Record review of the care plan dated 3/6/26 indicated Resident #30 has an ADL self-care performance deficit. Interventions include: Toilet use: requires staff x2 for assistance. Encourage the resident to discuss feelings about self-care deficit. Record review of the care plan revised dated 3/24/26 indicated Resident #30 has bladder incontinence and uses the pure wick system (urine collection system) for elimination. Interventions include nursing will monitor at least every 2 hours to ensure system is working and resident does not need to be cleansed and changed due to leakage. Staff will empty pure wick cannister as needed. Record review of Resident #30's Order Summary Report dated 3/24/26 indicated Resident #30 may use pure wick system (urine collection system) with a start date of 3/24/26. During an observation and interview on 3/23/26 at 10:12 A.M., Resident #30 was lying in bed resting. Resident has a pure wick system (urine collection system) on top of a portable tote in her room. Resident #30 stated staff did not know how to use it and they did not try to use the system per her and family request. During an interview on 3/24/26 at 10:54 A.M., a family member of Resident #30 stated she came last night and hooked the pure wick system (urine collection system) up for the resident. A family member of Resident #30 stated the day she brought the system to the facility a nurse stated the pure wick system was an amazing thing, but last night the nurse stated she was not sure if Resident #30 could use it in the facility. A family member of Resident #30 stated she was not sure if the staff knew how to use the system. A family member of Resident #30 stated Resident #30 really wanted to use the pure wick system (urine collection system), because the staff in the hospital used it on her and she loved it. During an interview on 3/25/26 at 9:12 A.M., Resident #30 lying in bed. Resident #30 stated that someone that was not a facility employee set up the pure wick system (urine collection system) for her, put it on her and it worked. Resident #30 stated that the nurse came in to change her stated the pure wick system (urine collection system) was not her favorite. Resident #30 stated she told the nurse she got the pure wick system (urine collection system) because she wanted to use it and it was better to use than urinating on herself. Resident #30 stated it made her mad that she had the pure wick system (urine collection system) and the staff do not want to use it. During an interview on 3/25/26 at 12:58 P.M., LVN F stated she knew a family member of Resident #30 brought the pure wick system (urine collection system) to the facility, but staff did not use those in our facility. LVN F stated Resident #30 said another staff member told her family she could use the pure wick system (urine collection system). LVN F stated she did not know anything about the pure wick system (urine collection system) until a family member of Resident #30 addressed it to her. LVN F stated no (continued on next page)

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	675177	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	2711 Pine Tree Rd Longview, TX 75604

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management told her the pure wick system (urine collection system) could not be used in the facility. She just told a family member of Resident #30 and the resident that the system could not be used, because she had never used one in a nursing facility. LVN F stated she was not aware that Resident #30 had an order for the pure wick system (urine collection system) to be used. LVN F stated she had never used one and she did not know how to use it. During an interview on 3/25/26 at 2:33 P.M., the Assistant Director of Nursing stated a family member of Resident #30 came and asked her about the system, and we explained to them our concerns about the system. The Assistant Director of Nursing stated the CNAs and nurses helped Resident #30 use the pure wick system. She stated she had seen the canister full, but she had not used the system on her Resident #30 herself. She stated the negative effect of not using the system at the resident's request was the consequences of incontinence. During interview on 3/25/26 at 3:54 P.M., the Director of Nursing stated Resident #30 could have the pure wick system if the family provided the supplies. The Director of Nursing stated a family member of Resident #30 verified the resident could use the system and she could instruct staff on where it needed to be placed. The Director of Nursing stated the aides were the staff placing the pure wick system (urine collection system) for Resident #30 with her guidance. She stated the negative effect of staff not helping Resident #30 use the system was she would have an incontinent episode that would require her to be changed if the system was not placed properly. During an interview on 3/25/26 at 4:10 P.M., the Administrator stated the facility was trying to get a policy for the pure wick system (urine collection system). She stated a family member of Resident #30 notified us the resident wanted to use the system; and she was taught in the hospital how to use it. The Administrator stated the nursing staff was responsible for emptying the canister. She stated Resident #30 was responsible for placing or assisting with the placement of the pure wick system (urine collection system), because she was taught how to use when she was in the hospital. She said she did not personally see a negative effect of staff not assisting the resident with the device. She said she thought it was more of a dignity issue for the resident. During an interview on 3/25/26 at 4:10 P.M., the Administrator stated the facility did not have a policy on pure wick system.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1of 1 resident (Resident #40) reviewed for enteral nutrition. The facility failed to ensure Resident #40's physician's order for his enteral feedings (a form of nutrition that is delivered into the digestive system as a liquid form via the feeding tube) was administered during the scheduled amount of time. This failure could affect residents by placing them at risk of dehydration and weight loss.The findings included: Record review of the face sheet, dated 3/24/26, reflected Resident #40 was a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of severe protein-calorie malnutrition, encounter for surgical aftercare following surgery on the digestive system, gastrostomy (a surgical opening for long-term enteral nutrition) and dysphagia (difficulty swallowing). Record review of the nursing home MDS assessment, dated 3/9/26, reflected Resident #40 had unclear speech, was usually understood by others, and was usually able to understand others. Resident #40 had a BIMS score of 4, which indicated severe cognitive impairment. Resident #40 usually required total assistance from staff with ADLs and was always incontinent of bowel and bladder. Nutritional: Malnutrition. Additional active diagnoses: Gastrostomy. Record review of the comprehensive care plan, dated 2/21/26, reflected Resident #40 has potential fluid deficit. Interventions include administering medications as ordered, monitoring, document for side effects and effectiveness. Record review of the comprehensive care plan, dated 3/6/26, reflected Resident #40 requires tube feeding related to dysphagia, swallowing problem. The interventions included: the resident is dependent on tube feeding and water flushes. See medical director's orders for current feeding orders. Registered Dietician to evaluate quarterly and PRN, monitor calorie intake, estimate needs, make recommendations for changes to tube feeding as needed. Record review of Resident #40's order summary report, reflected Isosource (nutritionally complete tube feeding formula) 1.5 calorie at 55 cc/hour via per peg-tube (a flexible feeding tube inserted through the abdomen into the stomach) 22 hours every shift related to gastrostomy status, start date 3/15/26. During an observation on 3/24/26 at 11:20 A.M., Resident #40 was lying in bed resting with peg-tube (a flexible feeding tube inserted through the abdomen into the stomach) hooked to enteral feeding bag and pump, with head of bed elevated. Resident feeding pump displayed Notice Pump Inactive. Pump has been idle for 10 minutes. Press Continue. The feeding pump was beeping with an orange and green light blinking. There was a small amount of liquid in the feeding bag which indicated there was not enough feeding in the bag to supply the pump. During an observation on 3/24/26 at 1:59 P.M., Resident #40 laid in bed with feeding bag and pump connected to peg-tube (a flexible feeding tube inserted through the abdomen into the stomach). The feeding pump continued to display Notice Pump Inactive. Pump has been idle for 10 minutes. Press Continue. The feeding pump was beeping with an orange and green light blinking. There was a small amount of liquid in the feeding bag which indicated there was not enough feed in the bag to supply the pump. During an interview on 3/24/26 at 2:03 P.M. LVN D stated Resident #40 should be getting his feeding all day. She stated that this was her first time changing his feeding and she was about to do it now. She stated the last time she checked his feeding was about 12:00 P.M. when she was passing out hall trays and it was not beeping. She stated his order and said he was supposed to be getting the peg-tube feeding 22 hours a day. During an interview on 3/24/26 at 3:51 P.M., the Assistant Director of Nursing stated when she went into Resident #40's room LVN D had already removed the old bag from the pump and spiked the new bag for the feeding pump. She stated she watched LVN D start the feeding without any assistance. The Assistant Director of Nursing stated Resident #40 was on 22 hours of peg-tube (a flexible feeding tube inserted through the abdomen into the stomach) feeding everyday with 2 hours of downtime with (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy, showers and gut rest. She stated his feeding should have been running from 11:20 A.M. to 2:03 P.M. She stated LVN D did not tell her that it was Resident #40's down time. She stated she expects him to down time during the day, her expectation was 3 hours was more down time than it should be. During an interview on 3/25/26 at 2:13 P.M., CNA E stated she remembered Resident #40's pump beeping yesterday. She stated she did not remember how long the pump was beeping. She stated she did round every 2 hours, and she observed the pump beeping during that time. She stated she did not remember what time she went in Resident #40's room. She stated when the pump was beeping it did not display Notice Pump Inactive. Pump has been idle for 10 minutes. Press Continue, when she was there. She stated the feeding was low in the bag when she was in the room and the tubbing from the pump was connected to Resident #40. She stated most of the time the feeding pump was running. She stated she did not honestly know the negative effect of the feeding not running when it should be. During an interview on 3/25/26 at 3:54 P.M., the Director of Nursing stated Resident #40 does have downtime. She sated Resident #40 had weight loss during his hospital stay. She said from 11:19 A.M.to 2:03 P.M. was not Resident #40's scheduled downtime. She stated she would expect his feeding to be running during that time. She stated the charge nurse on the floor was responsible for ensuring the feeding was running. She stated the negative effect was a potential weight loss. During an interview on 3/25/26 at 4:10 P.M., the Administrator stated she expected the feeding to be administered for the number of hours ordered. She stated the charge nurse, Assistant Director of Nursing and Director of Nursing were responsible for ensuring that the feeding was running appropriately. She stated the negative effect was that the resident weight could go down, and they may not get the effective nutrition for the day. Record review of the facility's policy Enteral Nutrition undated, indicated . We will provide nutritionally complete enteral or parental feedings as ordered by the physician for the nourishment of the residents who are unable to eat by mouth.1. The Nursing Services Department is responsible for all feeding equipment and the administration of tube feeding.5. Problems with the administration of the tube feeding are monitored and corrected by nursing.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 2 of 18 residents reviewed for respiratory care. (Resident #22 and Resident #55)The facility failed to ensure Resident #22's and Resident #55's oxygen concentrator had a clean filter.This failure could place residents at risk of respiratory complications or respiratory infection. Findings included: 1. Record review of a face sheet dated 03/24/26 indicated Resident #22 was [AGE] years old and admitted on [DATE] with diagnoses including dementia, chronic obstructive pulmonary disease (chronic lung disease), and acute and chronic respiratory failure.Record review of a physician's Order Summary Report dated 03/24/26 for Resident #22 did not include an order for cleaning the oxygen concentrator filter .Record review of a quarterly MDS dated [DATE] indicated Resident #22 understood others and was understood. The MDS indicated a BIMS of 12 indicating moderate cognitive impairment. The MDS indicated Resident #22 received oxygen therapy while she was a resident in the facility. Record review of a care plan last revised on 09/23/25 indicated Resident #22 had a diagnosis of chronic obstructive pulmonary disease with an intervention to give oxygen therapy as ordered by the physician. Record review of a Treatment Administration Record for Resident #22 dated 03/01/26 - 03/31/26 indicated an order to change or clean the filter of the nebulizer machine as needed on Sunday night. There was no documentation that the filter had been changed or cleaned from 03/01/26 - 03/25/26.During an observation on 03/23/26 at 9:56 a.m., Resident #22 was in bed. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator.During an observation on 03/24/26 at 8:27 a.m., Resident #22 was in bed. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator.During an observation on 03/25/26 at 9:17 a.m., Resident #22 was in bed. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator.2. Record review of a face sheet dated 03/24/26 indicated Resident #55 was [AGE] years old and admitted on [DATE] with diagnoses including dementia, chronic respiratory failure with hypoxia (low oxygen saturation), and diabetes.Record review of a physician's Order Summary Report dated 03/24/26 for Resident #55 did not indicate an order to change or clean the filter of the oxygen concentrator. There was an order for oxygen 3 liters per minute every shift with a start date of 11/01/25.Record review of a quarterly MDS dated [DATE] indicated Resident #55 understood others and was understood. The MDS indicated a BIMS of 13 indicating intact cognition. The MDS indicated Resident #55 received oxygen therapy while she was a resident in the facility. Record review of a care plan last revised on 10/22/25 indicated Resident #55 received oxygen therapy. There were no interventions concerning oxygen concentrator filters. Record review of a Treatment Administration Record for Resident #55 dated 03/01/26 - 03/31/26 did not indicate an order to change or clean the filter of the oxygen concentrator. There was no documentation that the filter had been changed or cleaned from 03/01/26 - 03/25/26.During an observation on 03/23/26 at 9:53 a.m., Resident #55 was sleeping in bed. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator.During an observation on 03/23/26 at 12:47 p.m., Resident #55 was in bed. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator.During an observation on 03/24/26 at 8:29 a.m., Resident #55 was asleep in bed. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator.During an observation on 03/25/26 at 9:20 a.m., Resident #55 was asleep in bed. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator.During an interview on 03/25/26 at 10:00 a.m., LVN C said the night shift nurses (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were responsible for cleaning the concentrator filters. She said the filters were supposed to be cleaned on Sunday nights. She said she had never checked to see if this had been done. She said it was important for clean filters to be on the concentrators because it filtered out infection, dust, polluted air, and kept the lungs clean. During an interview on 03/25/26 at 3:04 p.m., the DON said oxygen concentrator filters should be cleaned on Sunday nights by nursing staff. She said she would have expected for the filters for Resident #22 and Resident #55 to have been cleaned Sunday, 03/22/26. She said filters being cleaned was for infection control. She said cleaning filters was to make sure residents were not breathing in the wrong stuff and to make sure the concentrator continued to work properly. During an interview on 03/25/26 at 3:13 p.m., the Administrator said the night nurse on Sundays were responsible for washing and cleaning oxygen concentrator filter. She said she would have expected for the filters for Resident #22 and Resident #55 to have been cleaned this last Sunday night, 03/22/26. She said it was important for the filters to be clean because they catch all of the impurities and so that the air that was filtered through it was clean. Record review of an undated Oxygen Administration facility policy indicated, .Change or clean oxygen concentrator filters according to manufacturers' instructions.Record review of an undated Oxygen Services Customer Handbook by Mayo Clinic indicated on page 5, .Oxygen Concentrator.Once a week, the filter/intake of the concentrator should be cleaned or vacuumed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review and interview the facility failed to store all drugs and biologicals in locked compartments for 1 of 1 residents (Resident #54) reviewed for drug storage. The facility failed to securely store over the counter medications, (Nystatin Topical Powder) for Resident #54.This failure could place residents at risk for adverse reactions.Findings included:Record review of the face sheet dated 10/03/25 indicated Resident #54 was [AGE] years old female who was admitted on [DATE] with diagnoses including Hypothyroidism (an underactive thyroid condition where the gland fails to produce enough hormones to meet the body's needs, causing metabolism to slow), Hyperlipidemia (a common condition characterized by high levels of lipids (fats), such as cholesterol or triglycerides, in the blood, which can lead to plaque buildup in arteries), Bipolar Disorder (a chronic mental health condition characterized by extreme, often debilitating shifts in mood, energy, and activity levels, alternating between manic highs and depressive lows).Record review of the MDS dated [DATE] indicated Resident #54 was understood and understood others. The MDS indicated a BIMS score of 15 indicating Resident #54 was cognitively intact.Record review of a care plan revised on 10/06/25 indicated Resident #54 had an activities of daily livingself care performance Deficit.During an observation on 3/23/26 at 9:35 a.m. Resident #54 had two bottles of Nystatin Topical Powder in her room. She was not in the room to interview.During an interview and observation on 3/23/26 at 3:00 p.m. it was observed that Resident #54, had two bottles of Nystatin Topical Powder in her room. She said that she wanted to keep the powder in her room so she could use it herself. She said that staff had not taken it from her or told her she could not have it in the room.During an interview on 3/25/26 at 10:06 a.m. LVN C said that residents are not allowed to keep any medications in their room of any kind including nystatin topical powder. She said that residents could potentially misuse the medications or someone could come into the room who was allergic to the medications and misuse them. She said that all staff are responsible to ensure that medications are not left in residents' rooms and were stored properly.During an interview on 3/25/26 at 3:15 p.m. the Director of Nurses said that all medications should be stored in the medication or treatment cart. She said that it was the responsibility of nurses to ensure medications are stored properly. She said residents could be placed at risk if they misused the medications. During an interview on 3/25/26 at 3:27 p.m. the Administrator said that medications should always be kept in the medication cart when not being used by staff. She said that residents could be placed at risk if they misused the medications. She said that it was everyone's responsibility to ensure medications are not left in residents' rooms.Review of a facility policy titled, Medication Storage In the Facility reflected Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.The facility dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Transfer of medications from one container to another is done only by a pharmacist.Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relays the call directly to a centralized staff work area for 1 of 18 (Resident #5) residents reviewed for call lights.The facility failed to ensure Resident #5 had a functioning call light.This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity. Findings included: Record review of Resident 5's face sheet dated 03/24/26 indicated the resident was [AGE] years old and originally admitted to the facility on [DATE]. Resident #5 had diagnoses which included diabetes, chronic pulmonary edema (a condition caused by too much fluid in the lungs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).Record review of Resident #5's annual MDS assessment dated [DATE] indicated the resident was understood and understood others. Resident #5 had a BIMS score of 15, which indicated intact cognition. The MDS indicated Resident #5 required moderate assistance with toileting and supervision with other ADLs.Record review of Resident #5's care plan last revised 03/18/26 indicated the resident had bowel and bladder incontinence. There was an intervention to assist with toileting as needed. The care plan indicated Resident #5 had an ADL self-care performance deficit and required assistance from one staff member for most ADLs.During an observation and interview on 03/23/26 at 10:34 a.m., Resident #5 was sitting in her wheelchair in her room. LVN A was in the room. Resident #5's call light cord was completely broken away from the plug. LVN A walked into the room and said she could not fix the call light.During an observation 03/23/26 at 11:58 a.m., Resident #5 was in bed. Her call light was plugged into the outlet. The cord was broken and was not connected to the plug. During an observation 03/23/26 at 2:09 p.m., Resident #5 was asleep in bed. Her call light was plugged into the outlet. The cord was broken and was not connected to the plug. During an observation 03/24/26 at 8:29 a.m., Resident #5 was awake in bed. Her call light was plugged into the outlet. The cord was broken and was not connected to the plug. During an observation 03/24/26 at 10:19 a.m., Resident #5 was awake in bed. Her call light was plugged into the outlet. The cord was broken and was not connected to the plug. During an observation and interview 03/24/26 at 2:20 p.m., Resident #5 was awake in bed. Her call light was plugged into the outlet. The cord was broken and was not connected to the plug. She said she did not know how long her call light had been broken. She said when she needed help, she just yelled until someone would come to her room.During an interview on 03/24/26 at 2:46 p.m., LVN A said she remembered being in Resident 5's room and finding the call light broken. She said she did not report it to anyone. She said she should have reported it to the maintenance department. She said she did not know the process of reporting issues to maintenance. During an interview on 03/24/26 at 2:53 p.m., CNA B said he was the CNA for Resident #5. He said he had been in her room several times and he had not noticed her call light being broken. He said that he had fed Resident #5 her lunch. He said if a staff member had noticed the call light being broken, they should have reported it to maintenance. He said there was a QR code (a barcode that appears in a square pattern and stores encoded data) that hung on the wall that you scan. Then maintenance issues were submitted electronically.During an observation 03/24/26 at 4:13 p.m., Resident #5 was in bed. Her call light cord was completely broken away from the plug in the outlet.During an interview on 03/24/26 at 4:20 p.m., the Area Maintenance Supervisor said he needed to check the maintenance system to see if Resident 5's call light had been reported to the maintenance department. He said if staff were aware of the call light being broken on 03/23/26, he would have expected for it to have been reported then. He said when staff find maintenance issues, they should be scanning in the QR Code posted on the wall near the nurse's station to submit a maintenance request. He said the request then goes into the maintenance care system to create a work order. He demonstrated how to enter the request by putting in a request for Resident 5's call light to be repaired. During an interview (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	03/25/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 03/24/26 at 4:34 p.m., the Area Maintenance Supervisor said he had checked the maintenance system, and no staff member had entered a maintenance request until he did during the earlier demonstration. He said the call light had been repaired and the staff had been educated. During an interview on 03/25/26 at 3:04 p.m., the DON said she would have expected LVN A to have reported the call light being broken in Resident 5's room on 03/23/26. She said LVN A was new but the procedure for reporting maintenance issues had been covered in orientation. She said normally when a call light was not functioning, they provided the resident with a cow bell until it was repaired. She said it was important for residents to have a functioning call light so that they could notify staff that they were needing assistance.During an interview on 03/25/26 at 3:13 p.m., the Administrator said all call lights were supposed to function and if not, they were supposed to be reported to herself or the nurse. Then staff should put a repair request into the maintenance care system electronically. She said staff could verbally tell the Maintenance Supervisor. She said it was important for residents to have a call light so that they have a way to alert the staff if they have a need. During an interview on 03/25/26 at 3:31 p.m., the Regional Compliance Nurse said the facility did not have a functioning call light policy. Record review of an undated Resident Rights facility policy indicated, .The right to reside and receive services in the facility with reasonable accommodation of resident needs.