STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675550	A. Building B. Wing	10/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Tree Rehab and Healthcare Center	1900 E California St Gainesville, TX 76240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's physician and responsible party of a significant change in condition for one (Resident #1) of five residents reviewed for notification of changes. 1. The facility failed to notify Resident #1's responsible party when the resident's urinary catheter was found removed with the balloon intact, when the resident's antibiotic therapy was modified from being administered through a PICC line to oral and when the PICC line became clogged and was unable to be used.2. The facility failed to notify the physician of Resident #1's missed IV antibiotic doses and refused medications. This failure could place residents at risk for delayed medical evaluation, treatment, lack of timely involvement by the responsible party in resident care decisions and the potential for worsening of the resident's condition. Findings included: Record review of Resident #1's Face Sheet dated 10/15/25 reflected she was a [AGE] year-old female who admitted to the facility initially on 09/24/25 and re-admitted on [DATE] after a hospital stay and was discharged back to the hospital on [DATE]. Resident #1's principal admission diagnoses were sepsis (life-threatening condition that occurs when the body's immune system releases harmful chemicals in response to an infection) and a closed fracture of the right femur (broken thighbone). Secondary diagnoses included dementia with behavioral disturbance (a condition characterized by cognitive decline accompanied by significant changes in behavior and personality), Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), acute postprocedural pain (pain that occurs after a medical or surgical procedure and lasts for up to 3 months), inflammatory polyneuropathies (a group of disorders characterized by inflammation of the peripheral nerves, leading to damage and dysfunction) and direct infection of right hip in infectious and parasitic diseases. Record review of Resident #1's admission MDS assessment dated [DATE] reflected no BIMS score/assessment or cognitive pattern review. Resident #1 was sometimes understood by others and the MDS reflected ability is limited to making concrete requests and responds adequately to simple, direct communication only. Resident #1 had no wandering behaviors. Resident #1 was dependent on staff for ADLS and used a manual wheelchair for mobility. Resident #1 had range of motion impairment on one side of her lower extremity. Resident #1 was always incontinent of bowel and bladder and her primary reason for admission reflected, hip and knee replacement. Resident #1 had a fall prior to admission that resulted in a fracture. Additionally, Resident #1 had a major surgery within 100 days prior to admission that required SNF care. Resident #1 was at risk of developing pressure ulcers/injuries and had one surgical wound that required surgical wound care. Resident #1 was administered the following high-risk medications: anticoagulant, antibiotic and anticonvulsant. Resident #1 required a special treatment/procedure/program which included IV antibiotic administration via a midline (a long peripheral IV catheter inserted into a vein in the arm, with its tip terminating in the arm, not reaching the heart) upon admission. Record review of Resident #1's care plan initiated 09/25/25 and revised 10/08/25 reflected the following care areas all initiated on 10/08/25: A. Focus: Resident has a surgical site to: R hip with negative pressure wound therapy to right hip at -125 continuously. Res frequently pulls wound vac off despite education. May use wet to moist dressing if dislodged; B. Focus: The resident is on anticoagulant therapy.D. Focus: The resident has Intravenous (IV) Access. Resident #1's care plan did not reflect the use of a catheter. Record review of pertinent nursing notes related to Resident #1's change of condition reflected:-A nursing progress note by LVN A on 09/24/25 at 9:45 PM reflected Resident #1 pulled her PICC line out on her own and it was found next to her bed with no active bleeding at insertion site. There was no documentation to reflect the RP was notified. -A nursing progress note by LVN D the next morning on 09/25/25 at 8:45 AM reflected Nurse called [RP] for consent for insertion for new PICC line after resident pulled it out last night. Resident's [RP] consented to insertion of PICC line.-A nursing progress note by LVN A on 10/03/25 at 9:45 AM reflected Resident #1 pulled out her foley catheter (a thin, flexible tube inserted into the urethra to drain urine from the bladder) with the balloon (anchors the catheter in the bladder, preventing it from slipping out) intact and was found by the CNAs. Nurse assessment reflected there was no bleeding or obvious trauma noted. There was no documentation to reflect the RP was notified of the removal. -A nursing progress note by LVN A on 10/06/25 at 8:40 PM reflected, Resident pulled the IV pole down on her fall mat. She was in the fetal position at the FOB. Blood backed up into the infusion line (An IV line is used to deliver medicines, fluids, blood products, or nutrition into a patient's bloodstream) and is now clotted, unable to flush. [MD C] notified via text, awaiting new orders. There was no documentation to reflect the RP

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make prompt efforts to resolve grievances regarding the resident's care and treatment for one (Resident #1) of five residents reviewed for care concerns. The facility failed to document a grievance, respond and follow through on Resident #1's RP concerns when she voiced them to multiple management staff about poor nursing care and issues with her PICC line, wound vac, antibiotic medication and falls. This failure could place residents at risk for harm by allowing ongoing care concerns-including missed medications, PICC line and wound care issues, to go unaddressed, delaying necessary interventions and oversight.Findings included:Record review of Resident #1's Face Sheet dated 10/15/25 reflected she was a [AGE] year old female who admitted to the facility initially on 09/24/25 and re-admitted on [DATE] after a hospital stay and was discharged back to the hospital on [DATE]. Resident #1's principal admission diagnoses were sepsis (life-threatening condition that occurs when the body's immune system releases harmful chemicals in response to an infection) and a closed fracture of the right femur (broken thighbone). Secondary diagnoses included dementia with behavioral disturbance (a condition characterized by cognitive decline accompanied by significant changes in behavior and personality), Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), acute postprocedural pain (pain that occurs after a medical or surgical procedure and lasts for up to 3 months), inflammatory polyneuropathies (a group of disorders characterized by inflammation of the peripheral nerves, leading to damage and dysfunction), direct infection of right hip in infectious and parasitic diseases. Record review of Resident #1's admission MDS assessment dated [DATE] reflected no BIMS score/assessment or cognitive pattern review. Resident #1 was sometimes understood by others and the MDS reflected ability is limited to making concrete requests and responds adequately to simple, direct communication only. Resident #1 had no wandering behaviors. Resident #1 was dependent on staff for ADLS and used a manual wheelchair for mobility. Resident #1 had range of motion impairment on one side of her lower extremity (the parts of the body from the hips down to the feet, including the thighs, knees, legs, ankles, and toes). Resident #1 was always incontinent of bowel and bladder and her primary reason for admission reflected, hip and knee replacement. Resident #1 had a fall prior to admission that resulted in a fracture. Additionally, Resident #1 had a major surgery within 100 days prior to admission that required SNF care. Resident #1 was at risk of developing pressure ulcers/injuries and had one surgical wound that required surgical wound care. Resident #1 was administered the following high risk medications: anticoagulant, antibiotic and anticonvulsant. Resident #1 required a special treatment/procedure/program which included IV antibiotic administration via a midline upon admission. Record review of Resident #1's care plan initiated 09/25/25 and revised 10/08/25 reflected the following care areas: A. Focus: Resident has a surgical site to: R hip with negative pressure wound therapy to right hip at -125 continuously (a treatment that uses suction to aid healing in chronic or non-healing wounds), B. Focus: The resident is on anticoagulant therapy. (Date Initiated: 10/08/25), C. Focus: The resident has Hip Fracture. (Date Initiated: 10/08/25), D. Focus: The resident has Intravenous (IV) Access. (Date Initiated: 10/08/25) and E. Focus: The resident is risk for falls (Date Initiated: 10/08/25).Record review of Resident #1's medication order summary for September 2025 and October 2025 reflected she required extensive wound care and IV therapy following her readmission with a right hip infection and sepsis. Resident #1's physician orders directed that the surgical wound to the right hip be cleaned with normal saline, packed with gauze and draped daily with a negative pressure wound therapy vac (a medical device that uses suction to promote wound healing) to remain in place continuously at 125 mmHg. Resident #1 also had standing orders for IV antibiotics, including Cefazolin every eight hours and Bactrim DS for bacterial infection and Lovenox for prevention of blood clots. Additional physician instructions included daily saline flushes to maintain IV line patency (the state of being open or unobstructed, allowing for the free flow of fluids, air, or blood) and wet-to-moist dressing changes if the vac became dislodged.An interview with Resident #1's RP on 10/15/25 at 2:02 PM revealed she was not notified when the resident's PICC line was not able to be flushed and used to administer the IV medications. She stated when she saw the PICC line tubing, it appeared black and crusted, and she became aware of the issue only during a visit. The RP also stated staff did not contact her to inform her that Resident #1's IV antibiotic therapy had been stopped and change to oral medications until after the change was made. The RP stated the nursing staff told her she would be fine taking oral medications, but she was concerned

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time-frames to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of five residents reviewed for care plans. The facility failed to revise Resident #1's care plan after she fell on [DATE] to include updated fall prevention interventions and nursing management's identification of 1:1 supervision needs. The failure could place residents at risk for additional falls and injury by delaying the implementation and documentation of required supervision and safety interventions following a known fall event. Findings included: Record review of Resident #1's Face Sheet dated 10/15/25 reflected she was a [AGE] year old female who admitted to the facility initially on 09/24/25 and re-admitted on [DATE] after a hospital stay and was discharged back to the hospital on [DATE]. Resident #1's principal admission diagnoses were sepsis (life-threatening condition that occurs when the body's immune system releases harmful chemicals in response to an infection) and a closed fracture of the right femur (broken thighbone). Secondary diagnoses included dementia with behavioral disturbance (a condition characterized by cognitive decline accompanied by significant changes in behavior and personality), Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), acute postprocedural pain (pain that occurs after a medical or surgical procedure and lasts for up to 3 months), inflammatory polyneuropathies (a group of disorders characterized by inflammation of the peripheral nerves, leading to damage and dysfunction), direct infection of right hip in infectious and parasitic diseases. Record review of Resident #1's admission MDS assessment dated [DATE] reflected no BIMS score/assessment or cognitive pattern review. Resident #1 was sometimes understood by others and the MDS reflected ability is limited to making concrete requests and responds adequately to simple, direct communication only. Resident #1 had no wandering behaviors. Resident #1 was dependent on staff for ADLS and used a manual wheelchair for mobility. Resident #1 had range of motion impairment on one side of her lower extremity (the parts of the body from the hips down to the feet, including the thighs, knees, legs, ankles, and toes). Resident #1 was always incontinent of bowel and bladder and her primary reason for admission reflected, hip and knee replacement. Resident #1 had a fall prior to admission that resulted in a fracture. Additionally, Resident #1 had a major surgery within 100 days prior to admission that required SNF care. Record review of Resident #1's Fall Risk Assessment completed dated 09/24/25 reflected a score of 11, which indicated she was a high-risk. Record review of a nursing progress note dated 10/07/25 at 12:15 PM by ADON G reflected Resident #1 had an unwitnessed fall in her room from a low bed and was discovered on the floor next to her bed. The progress note further reflected, Another resident alerted staff that resident was observed to be on the floor. Upon entering the room resident was next to bed already attempting to get back up and on knees next to w/c. Res unable to answer questions regarding intent. Res obs for injury, Neuro's (assesses the nervous system through a combination of tests on mental status, cranial nerves, motor and sensory function, coordination and balance, and reflexes) initiated, VS stable. Denies any c/o pain. Res assisted w/ 2 assist up to w/c No Pain. Interventions noted to be in place prior to fall were a floor mat and low bed. Interventions initiated in response to the fall were documented as, 1 on 1 supervision (involves a dedicated caregiver providing constant, undivided attention to prevent falls and ensure safety due to cognitive impairment). Record review of Resident #1's Transfer Notification nursing note dated 10/08/25 at 1:27 PM by ADON G reflected the resident had a fall at the nurses' station and hit her head. The fall caused an abrasion to the left side of the head. Resident #1 was noted to react to painful stimuli with any attempts to move her bilateral lower extremities and was bleeding. The nursing note further reflected, Resident was sitting in w/c at nurses' station when staff heard her scream. She was noted to be standing up and attempting to walk. She lost balance and hit her head against the nurses' station and landed on left side of body. No LOC noted and mentation (the overall mental activity of the mind, including thinking, memory, reasoning, perception, and consciousness) remained at baseline. VS assessed. Neuros assessed. Attempted to locate wounds/injury. EMS called. [RP] notified.Interventions in place prior to fall: 1 on 1 supervision. T Record review of Resident #1's care plan initiated 09/25/25 reflected a focus area/interventions for falls was initiated on 10/08/25 by the CCN and reflected, Focus: The resident is risk for

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of five residents reviewed for quality of care. 1. The facility failed to ensure Resident #1's wound vac was providing the proper suction and failed to have her infected surgical wound assessed by the wound care physician or attending physician to determine the proper course of action, despite reports of complications. 2. The facility did not ensure proper management of Resident #1's clotted PICC line when it became clotted. Additionally, there was no dressing assessment documented for the PICC line. As a result of the PICC line not flushing, IV antibiotics were discontinued for the right hip surgical wound on 10/06/07 and oral antibiotics were started without addressing the central line's compromised condition. 3. Resident #1 had an unwitnessed fall on 10/07/25 with no noted injuries. After the fall, neurochecks were not completed per protocol from 10/07/25 to 10/08/25. On 10/08/25, Resident #1 fell again at the nurses' station and sustained a head injury. She was sent to the ER where it was determined she also had a left hip fracture.An IJ was identified on 10/17/25 at 11:48 AM. The IJ template was provided to the facility on [DATE] at 11:38 AM. While the IJ was removed on 10/18/25, the facility remained out of compliance at a scope of no actual harm and a severity level of pattern because the facility continued to monitor the implementation and effectiveness of their Plan of Removal and all nursing staff had not been trained on PICC line, neurochecks and wound vac therapy.These failures could result in could place residents at risk of not receiving care and treatment needed which could lead to avoidable decline and life-threatening complications.Findings included: Record review of Resident #1's Face Sheet dated 10/15/25 reflected she was a [AGE] year old female who admitted to the facility initially on 09/24/25 and re-admitted on [DATE] after a hospital stay and was discharged back to the hospital on [DATE]. Resident #1's principal admission diagnoses were sepsis (life-threatening condition that occurs when the body's immune system releases harmful chemicals in response to an infection) and a closed fracture of the right femur (broken thighbone). Secondary diagnoses included dementia with behavioral disturbance (a condition characterized by cognitive decline accompanied by significant changes in behavior and personality), Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), acute postprocedural pain (pain that occurs after a medical or surgical procedure and lasts for up to 3 months), inflammatory polyneuropathies (a group of disorders characterized by inflammation of the peripheral nerves, leading to damage and dysfunction), direct infection of right hip in infectious and parasitic diseases. Record review of Resident #1's admission MDS assessment dated [DATE] reflected no BIMS score/assessment or cognitive pattern review. Resident #1 was sometimes understood by others- ability is limited to making concrete requests and responds adequately to simple, direct communication only. Resident #1 had no signs or symptoms of delirium and no negative mood issues. Resident #1 had no potential indicators of psychosis and no behavioral symptoms, no rejection of care issues and no wandering behaviors. Resident #1 was dependent on staff for ADLS and used a manual wheelchair for mobility. Resident #1 had range of motion impairment on one side of her lower extremity. Resident #1 always incontinent of bowel and bladder and her primary reason for admission reflected, hip and knee replacement. Resident #1 had a fall prior to admission that resulted in a fracture. Additionally, Resident #1 had a major surgery within 100 days prior to admission that required SNF care. Resident #1 was at risk of developing pressure ulcers/injuries and had one surgical wound that required surgical wound care. Resident #1 was administered the following high-risk medications: anticoagulant (blood thinner), antibiotic and anticonvulsant. Resident #1 required a special treatment/procedure/program which included IV antibiotic administration via a midline upon admission. Record review of Resident #1's care plan initiated 09/25/25 and revised 10/08/25 reflected the following care areas: A. Focus: Resident has a surgical site to: R hip with negative pressure wound therapy to right hip at -125 continuously. Res frequently pulls wound vac off despite education. May use wet to moist dressing if dislodged (Date initiated: 09/25/25); Interventions/Tasks: 1) Surgeon follow up as needed. Assist resident/RP with scheduling/transportation as needed (Date Initiated: 09/25/25), Observe for s/s of infection-increased redness, increased pain, drainage. Report to physician if noted (Date Initiated: 09/25/25), Observe for s/s of pain during treatment and medicate PRN per physician's orders (Date Initiated: 09/25/2025), negative pressure therapy continuously (a treatment that uses continuous or intermittent negative pressure to promote wound healing. It involves applying a special

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of five residents reviewed for accident hazards/supervision . The facility failed to implement and maintain 1:1 supervision for Resident #1 as was recommended by nursing management following a fall on 10/07/25. On 10/08/25, Resident #1 fell at the nurses' station while not under 1:1 supervision and sustained another fall, striking her head on the counter and fracturing her left hip. An IJ was identified on 10/17/25 at 11:48 AM. The IJ template was provided to the facility on [DATE] at 11:38 AM. While the IJ was removed on 10/18/25, the facility remained out of compliance at a scope of no actual harm and a severity level of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal and because all nursing staff had not been trained on fall and supervision protocols related to enhanced and 1:1 supervision needs of high-fall risk residents. This failure placed residents at risk for significant injury, hospitalization or death due to not having adequate supervision to prevent accidents. Findings included: Record review of Resident #1's Face Sheet dated 10/15/25 reflected she was a [AGE] year-old female who admitted to the facility initially on 09/24/25 and re-admitted on [DATE] after a hospital stay and was discharged back to the hospital on [DATE]. Resident #1's principal admission diagnosis was sepsis (life-threatening condition that occurs when the body's immune system releases harmful chemicals in response to an infection) and a closed fracture of the right femur (broken thighbone). Secondary diagnoses included dementia with behavioral disturbance (a condition characterized by cognitive decline accompanied by significant changes in behavior and personality), Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), acute postprocedural pain (pain that occurs after a medical or surgical procedure and lasts for up to 3 months), inflammatory polyneuropathies (a group of disorders characterized by inflammation of the peripheral nerves, leading to damage and dysfunction), direct infection of right hip in infectious and parasitic diseases. Record review of Resident #1's admission MDS assessment dated [DATE] reflected no BIMS score/assessment or cognitive pattern review. Resident #1 was sometimes understood by others- ability is limited to making concrete requests and responds adequately to simple, direct communication only. Resident #1 had no signs or symptoms of delirium and no negative mood issues. Resident #1 had no potential indicators of psychosis and no behavioral symptoms, no rejection of care issues and no wandering behaviors. Resident #1 was dependent on staff for ADLS and used a manual wheelchair for mobility. Resident #1 had range of motion impairment on one side of her lower extremity. Resident #1 always incontinent of bowel and bladder and her primary reason for admission reflected, hip and knee replacement. Resident #1 had a fall prior to admission that resulted in a fracture. Additionally, Resident #1 had a major surgery within 100 days prior to admission that required SNF care. Resident #1 was at risk of developing pressure ulcers/injuries and had one surgical wound that required surgical wound care. Resident #1 was administered the following high risk medications: anticoagulant, antibiotic and anticonvulsant. Resident #1 required a special treatment/procedure/program which included IV antibiotic administration via a midline upon admission. Record review of Resident #1's care plan initiated 09/25/25 reflected E. Focus: The resident is risk for falls (Date Initiated: 10/08/25); Interventions/Tasks: 1) Anticipate and meet the resident's needs (Date Initiated: 10/08/25), 2) Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed (Date Initiated: 10/08/25), 3) Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs (Date Initiated: 10/08/25), Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility (Date Initiated: 10/08/25), Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c (Date Initiated: 10/08/25), Keep furniture in locked position (Date Initiated: 10/08/25), Keep needed items, water, etc, in reach (Date Initiated: 10/08/25), Pt evaluate and treat as ordered or PRN (Date Initiated: 10/08/25), Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes (Date Initiated: 10/08/25), Staff x 2 to assist with transfers (Date Initiated: 10/08/25), The resident needs a safe environment (Date Initiated: 10/08/25), The resident needs activities that minimize the potential for falls while providing diversion and distraction (Date Initiated: 10/08/25). Record review of Resident #1's admission Nursing Note by LVN A dated 09/24/25 reflected she admitted at 6:00 PM with her responsible party from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675550	A. Building B. Wing	10/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Tree Rehab and Healthcare Center	1900 E California St Gainesville, TX 76240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement with a licensed pharmacy in a timely manner and that drugs are administered as ordered by the physician for one (Resident #1) of five residents reviewed for pharmacy services. The facility did not administer Resident #1's prescribed IV antibiotics through her PICC line or her ordered Lovenox injections following a surgery for a right hip fracture sustained from a prior fall. The facility also failed to ensure these medications were obtained from the pharmacy and available for timely administration as ordered by the physician. This failure placed residents at risk of not receiving medications as prescribed in order to meet residents needs.Findings included:Record review of Resident #1's Face Sheet dated 10/15/25 reflected she was a [AGE] year old female who admitted to the facility initially on 09/24/25 and re-admitted on [DATE] after a hospital stay and was discharged back to the hospital on [DATE]. Resident #1's principal admission diagnoses were sepsis (life-threatening condition that occurs when the body's immune system releases harmful chemicals in response to an infection) and a closed fracture of the right femur (broken thighbone). Secondary diagnoses included dementia with behavioral disturbance (a condition characterized by cognitive decline accompanied by significant changes in behavior and personality), Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), acute postprocedural pain (pain that occurs after a medical or surgical procedure and lasts for up to 3 months), inflammatory polyneuropathies (a group of disorders characterized by inflammation of the peripheral nerves, leading to damage and dysfunction), direct infection of right hip in infectious and parasitic diseases. Record review of Resident #1's admission MDS assessment dated [DATE] reflected no BIMS score/assessment or cognitive pattern review. Resident #1 was sometimes understood by others- ability is limited to making concrete requests and responds adequately to simple, direct communication only. Resident #1 had no signs or symptoms of delirium and no negative mood issues. Resident #1 had no potential indicators of psychosis and no behavioral symptoms, no rejection of care issues and no wandering behaviors. Resident #1 was dependent on staff for ADLS and used a manual wheelchair for mobility. Resident #1 had range of motion impairment on one side of her lower extremity. Resident #1 always incontinent of bowel and bladder and her primary reason for admission reflected, hip and knee replacement. Resident #1 had a fall prior to admission that resulted in a fracture. Additionally, Resident #1 had a major surgery within 100 days prior to admission that required SNF care. Resident #1 was at risk of developing pressure ulcers/injuries and had one surgical wound that required surgical wound care. Resident #1 was administered the following high risk medications: anticoagulant, antibiotic and anticonvulsant. Resident #1 required a special treatment/procedure/program which included IV antibiotic administration via a midline upon admission. Record review of Resident #1's care plan initiated 09/25/25 and revised 10/08/25 reflected the following care areas: Focus: The resident is on anticoagulant therapy. (Date Initiated: 10/08/25)-Interventions/Tasks: Monitor/document/report to MD PRN s/sx of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB, Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (Date Initiated: 10/08/2025) Focus: The resident has Intravenous (IV) Access. (Date Initiated: 10/08/25)-Interventions/Tasks: 1) Administer IV fluids as ordered (Date Initiated: 10/08/25), Administer IV medications as ordered (Date Initiated: 10/08/25), Check dressing at site daily. Monitor for signs and symptoms of infection, Drainage, Inflammation, Swelling, Redness, Warmth. if present notify the physician (Date Initiated: 10/08/25), Flush the ports/lines as ordered (Date Initiated: 10/08/25), If Tegaderm (a transparent medical dressing used to cover and protect wound sites); change dressing every 7 days and prn-If gauze dressing change every 48 hours (Date Initiated: 10/08/2025), the resident has PICC line IV access (Date Initiated: 10/08/2025). Record review of a facility admission Alert-Communication Alert for Approved Admissions for Resident #1 dated 09/24/25 at 3:36 PM and signed by LVN Q reflected the resident's ETA was 6:00 PM and her special requirements included ADL assist, IV meds and wounds. Equipment needs included PICC line and wound vac. A copy of the hospital discharge orders were included in the alert and reflected Resident #1 had Cefazolin (Ancef) 2 grams intravenously every eight hours and Ertapenem one gram intravenously every day. Record review of Resident #1's order summary reflected the prescribing physician was MD C; -Cefazolin Sodium Injection

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	675550	A. Building B. Wing	10/18/2025

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents are free of any significant medication errors for one (Resident #1) of five residents reviewed for pharmacy services. The facility did not administer Resident #1's prescribed IV antibiotics through her PICC line or her ordered Lovenox injections following a surgery for a right hip fracture sustained from a prior fall. This failure placed residents at risk of not receiving medications as prescribed in order to meet residents needs.Findings included:Record review of Resident #1's Face Sheet dated 10/15/25 reflected she was a [AGE] year old female who admitted to the facility initially on 09/24/25 and re-admitted on [DATE] after a hospital stay and was discharged back to the hospital on [DATE]. Resident #1's principal admission diagnoses were sepsis (life-threatening condition that occurs when the body's immune system releases harmful chemicals in response to an infection) and a closed fracture of the right femur (broken thighbone). Secondary diagnoses included dementia with behavioral disturbance (a condition characterized by cognitive decline accompanied by significant changes in behavior and personality), Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), acute postprocedural pain (pain that occurs after a medical or surgical procedure and lasts for up to 3 months), inflammatory polyneuropathies (a group of disorders characterized by inflammation of the peripheral nerves, leading to damage and dysfunction), direct infection of right hip in infectious and parasitic diseases. Record review of Resident #1's admission MDS assessment dated [DATE] reflected no BIMS score/assessment or cognitive pattern review. Resident #1 was sometimes understood by others- ability is limited to making concrete requests and responds adequately to simple, direct communication only. Resident #1 had no signs or symptoms of delirium and no negative mood issues. Resident #1 had no potential indicators of psychosis and no behavioral symptoms, no rejection of care issues and no wandering behaviors. Resident #1 was dependent on staff for ADLS and used a manual wheelchair for mobility. Resident #1 had range of motion impairment on one side of her lower extremity. Resident #1 always incontinent of bowel and bladder and her primary reason for admission reflected, hip and knee replacement. Resident #1 had a fall prior to admission that resulted in a fracture. Additionally, Resident #1 had a major surgery within 100 days prior to admission that required SNF care. Resident #1 was at risk of developing pressure ulcers/injuries and had one surgical wound that required surgical wound care. Resident #1 was administered the following high risk medications: anticoagulant, antibiotic and anticonvulsant. Resident #1 required a special treatment/procedure/program which included IV antibiotic administration via a midline upon admission. Record review of Resident #1's care plan initiated 09/25/25 and revised 10/08/25 reflected the following care areas: Focus: The resident is on anticoagulant therapy. (Date Initiated: 10/08/25)-Interventions/Tasks: Monitor/document/report to MD PRN s/sx of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB, Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (Date Initiated: 10/08/2025) Focus: The resident has Intravenous (IV) Access. (Date Initiated: 10/08/25)-Interventions/Tasks: 1) Administer IV fluids as ordered (Date Initiated: 10/08/25), Administer IV medications as ordered (Date Initiated: 10/08/25), Check dressing at site daily. Monitor for signs and symptoms of infection, Drainage, Inflammation, Swelling, Redness, Warmth. if present notify the physician (Date Initiated: 10/08/25), Flush the ports/lines as ordered (Date Initiated: 10/08/25), If Tegaderm (a transparent medical dressing used to cover and protect wound sites); change dressing every 7 days and prn-If gauze dressing change every 48 hours (Date Initiated: 10/08/2025), the resident has PICC line IV access (Date Initiated: 10/08/2025). Record review of a facility admission Alert-Communication Alert for Approved Admissions for Resident #1 dated 09/24/25 at 3:36 PM and signed by LVN Q reflected the resident's ETA was 6:00 PM and her special requirements included ADL assist, IV meds and wounds. Equipment needs included PICC line and wound vac. A copy of the hospital discharge orders were included in the alert and reflected Resident #1 had Cefazolin (Ancef) 2 grams intravenously every eight hours and Ertapenem one gram intravenously every day. Record review of Resident #1's order summary reflected the prescribing physician was MD C: -Cefazolin Sodium Injection Solution Reconstituted 2 GM Use 2 gram intravenously every 8 hours for infection, R hip (Start Date 09/25/25); -Ertapenem Sodium Solution Reconstituted 1 GM Use 1 gram intravenously every 24 hours for infection, R hip for 1 Day (start date 09/24/25) and Lovenox Injection Solution Prefilled Syringe 40 MG/0.4ML