| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675550 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pecan Tree Rehab and Healthcare Center | 1900 E California St<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident was free from abuse for one (Resident #4) out of 5 residents reviewed for abuse and neglect. The facility failed to ensure the LVN did not cause mental anguish to Resident #4 when she accused her of pulling her I.V. out for attention. This failure could place residents at risk for abuse, neglect and a decline in psychosocial well-being.Record review of Resident #4's face sheet revealed she was an [AGE] year-old female who was admitted [DATE]. Her diagnoses included: Displaced Fracture of base of neck of Right Femur (serious hip injury where bone is broken and shifted out of place), Unspecified Fracture of Right Patella (broken kneecap), Essential Hypertension (high blood pressure), Unspecified Atrial Fibrillation (presence of rapid, irregular heart rhythm), and Dizziness (lightheaded). Record review of Resident #4's Admissions MDS dated [DATE] revealed a BIMS of 9 which meant moderate cognitive impairment. Resident #4's MDS revealed she had the ability to understand others with clear comprehension. Record review of Resident #4's Care Plan dated 5/11/26 and revised on 5/12/26 revealed she had an ADL self-care deficit, and a history of trauma that may have a negative impact. The trauma was related to a verbal conversation with staff member. Interventions were listed as:arrange for licensed mental health provider as ordered by physicianif resident is escalated, do not touch the residentto monitor for escalating anxiety, depression or suicidal thought and report immediately to the nurse. Record review of Resident #4's Progress Notes on 5/8/26 at 11:36 p.m. written by the LVN revealed Resident #4 had pulled her iv out of her arm with about 25% of fluid left in iv bag resident reports she didn't realize she had pulled it out. Record review of Tulip revealed a report was called in on 5/11/26 regarding the alleged abuse of Resident #4 by the LVN. Interview on 5/12/26 at 9:48 a.m. the ADON stated Resident #4 pushed her call light to let nurse know her I.V. came out. Resident #4's FM was on the phone when the LVN came in saying she pulled out her I.V. for attention but the resident stated she had not. The ADON stated the FM thought the LVN saw she was on the phone and the LVN changed her attitude. Interview on 5/12/26 at 9:50 a.m. the Admin. stated Resident #4 called the LVN the mean nurse. The Admin. stated the LVN reportedly told Resident #4 she took out her I.V. on purpose. The Admin. found out about potential abuse yesterday, 5/11/26, when the FM called the SW. The SW had him and the ADON come into her office. He stated that was why he called in the report right after he heard about it. The Admin. stated Resident #4 was a little emotional and cried a little bit. He suspended the LVN immediately pending investigation to make sure no psychosocial issues were going on but otherwise, Resident #4 was fine. Interview on 5/12/26 at 10:54 a.m. Resident #4 stated the LVN accused her of taking her I.V. out on purpose. She stated it made her feel awful as (she) did not do stuff like that. Resident #4 stated her FM was on the phone and heard what happened. She stated the FM called the facility and let them know. Resident #4 stated she felt like all that should happen was the LVN was moved off her hall and that was done. Interview on 5/12/26 at 1:13 p.m. Resident #4's FM stated she was on the phone when the incident happened with the LVN. The FM stated Resident #4 accidentally called her without knowing. The FM stated the LVN was in the room, and she heard her chewing her (Resident #4) out and accusing her of pulling her<br>(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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | I.V. out for attention. The FM stated the LVN was treating her like crap. She stated Resident #4 was crying and said she did not do it on purpose and that she did not do it for attention, I promise. The FM stated she felt the LVN was very ugly to Resident #4. She stated the LVN must have noticed she was on the phone because she changed her behavior and was saying Oh baby it is ok; everything is going to be ok. The FM stated Resident #4, and she referred to the LVN as the mean nurse. The FM stated Resident #4 was afraid to death of her and did not want to take medications from her anymore. The FM stated she called the SW on 5/11/26 and let her know what had taken place. She stated Resident #4 told her she did not want anyone to get in trouble. The FM told her she did not need to be abused either. The FM stated she felt Resident #4 would be fine after the incident and the facility stated they would not have the LVN working on her hall anymore. Interview on 5/12/26 at 2:19 p.m. the SW stated she talked to Resident #4's FM yesterday (5/11/26). The SW stated the FM had to call her back, so she had the ADMIN. and ADON in the room and had the FM on speaker phone. The SW stated the FM stated the LVN had gone into Resident #4's room and berated her for pulling her I.V. out. The SW stated the FM stated the LVN's behavior changed when she must have seen the FM was on the phone. The SW stated she interviewed Resident #4 for trauma but there was nothing lingering. She had made multiple checks on Resident #4 and she was fine. The SW had not heard any complaints regarding the LVN before. She stated people complained about staff, but not to this level. The SW stated the FM said Resident #4 was crying when the LVN was talking to her. Interview on 5/12/26 at 2:40 p.m. the LVN stated Friday evening, 5/8/26, Resident #4's call light was on, and she went in and saw her I.V. had dislodged. She stated she told Resident #4 you pulled your I.V. out. The LVN stated Resident #4 said it must have happened when she was choking. The LVN stated she told her she was ok. The LVN denied telling Resident #4 she did it on purpose or for attention but did tell her she pulled it out. She denied Resident #4 was crying and stated there were no tears. The LVN stated she did not know the FM was on the phone during the conversation. She stated the FM would have heard the entire conversation. The LVN stated she had never had any problems/complaints before. She stated she was written up for telling an aide to take care of the residents. The LVN stated if she or any staff had talked to any resident accusing them of pulling their I.V. out for attention, the resident could think they did something wrong when they did not. The LVN stated she thought the FM took the conversation out of context and stated 25% of the conversation was coddling Resident #4, not accusing her. Interview on 5/12/26 at 2:58 p.m. the DON stated on 5/11/26, she did a head-to-toe assessment on Resident #4, talked to her, and let her know to talk to her if she was feeling a certain way. She stated the LVN would not be taking care of Resident #4 anymore and she assured the family members. The DON stated she had never had any issues with the LVN personally before but knew she had been written up in the past. She stated the former management team possibly had an issue with the LVN. The DON stated she was surprised the allegation came in regarding the LVN as she had been so attentive towards Resident #4. The DON stated a resident being accused of something like pulling their I.V. out or being talked down to, could cause psychosocial harm to the resident. Interview on 5/12/26 at 3:10 p.m. the Admin. stated the LVN had been written up before he started working at the facility with the new management team on 3/16/26. He stated he could not act on anything that was before he started at the facility. He stated when he found out this potentially happened, he suspended her immediately and planned on letting the LVN go. The Admin. stated what the LVN did was abuse. Record review of the facility's Abuse/Neglect policy dated 3/29/18 revealed The resident has the right to be free from abuse.Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff.Under Definitions:Abuse is the willful infliction of.intimidation, or punishment with resulting.mental anguish.It includes verbal abuse.and mental abuse. 6. Mental Abuse: includes, but is not limited to, humiliation, harassment. Under Prevention: The facility will provide the residents, families, and staff an environment free from abuse and neglect. |