STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observations, interviews, and record review the facility failed to ensure the resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 5 residents (Resident #77) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system was within reach of the Resident #77, who was sitting in a wheelchair by the foot of the bed. This failure could place residents in the facility at risk of being unable to have a means of directly contacting caregivers. Findings included: Record review of Resident #77's MDS assessment dated [DATE] reflected Resident #77 was an [AGE] year-old female with a BIMS score 03 of 15, indicating severe cognitive impairment. Resident #77 was admitted to the facility on [DATE] with the diagnoses of Diabetes Mellitus (elevated blood sugar), Dementia (a progressive loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and hypertension (elevated blood pressure). The review further reflected the resident was totally dependent on staff for the ADLs . Record review of Resident #77's Comprehensive Care Plan dated 11/11/24 reflected Focus. Resident#77 has impaired cognitive function/dementia or impaired thought process related to .impaired decision making. Goal. The Resident#77 Will be able to communicate basic needs on a daily basis through the review date. Interventions. Keep the Resident's routine consistent . in order to decrease confusion. Record review revealed no intervention of keeping the call light within reach of the resident. Observation on 11/13/24 at 08:43 AM revealed Resident#77 was sitting in her wheelchair by the foot of the bed, and the call light was lying by the head of the bed. Resident#77 stated she could not reach the call light. This state surveyor called LVN F inside the Resident#77's room and pointed to the call light by the head of the bed. LVN F stated the call light was not within reach of Resident#77. He took the call light and placed it closer to Resident#77 by the foot of the bed. Resident#77 took the call light and held it in her hand. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER: Pecan Tree Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1900 E California St Gainesville, TX 76240	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 08:53 AM LVN F stated the call light was not within reach of the Resident#77. LVN F stated the call light should be within residents' reach all the time. LVN F stated the risk to the resident was not getting help he/she needed. LVN F stated it was the responsibility of all the staff to make sure the call light was within resident reach before exiting the room. Interview on 11/13/24 at 10:05 AM the DON stated his expectation was the call light should be always within resident reach. He stated it was the responsibility of all staff to make sure the call light is within resident reach. The DON stated the risk to residents, if the call light was not within resident reach or did not work properly, was the residents could not call for help. Review of the facility policy titled Call Lights: Accessibility and Timely Response, revised 05/01/2024 revealed The purpose of this policy is to assure the facility is adequately equipped with a call light to allow residents to call for assistance .5. Staff will ensure the call light is within reach of resident and secured, as needed.

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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 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** 47690 Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable environment, including but not limited to receiving treatments and supports for daily living for 1 of 5 residents (Resident #102) reviewed for quality of life. Facility staff/Hospice Aide failed to provide Resident #102 with clean linens. These failures could affect the residents by causing infections and skin issues. Findings include: A record review of Resident #102's MDS assessment dated [DATE] reflected Resident #102 was a [AGE] year-old male with a BIMS score of 00 of 15, indicating severe cognitive impairment. Resident #102 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's disease, Dementia (a progressive loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), depression, and anxiety. The review further reflected the resident was on hospice services, and totally dependent on staff for the ADLs. A record review of Resident #102's Comprehensive Care Plan initiated date 10/01/24 reflected Problem. Resident#102 has a terminal prognosis related to senile degenerative of the brain. Utilized: Hospice services. Goal. Resident#102's comfort Will be maintained through the review date. Interventions .Keep the environment quiet and calm, keep linens clean, dry, and wrinkle free . Work with the nursing staff to provide maximum comfort for the resident. Observation on 11/13/24 at 07:55 AM of Resident #102 revealed that he was walking in the hall wearing daytime attire. Resident #102's linen (fitted sheet) was soiled with a feces smear at the middle of the bed, where Resident#102 would be if he was sitting at the edge of the bed. Resident#102 was unable to respond to interview. Observation and interview on 11/13/24 at 01:27 PM revealed Resident #102's bed still had the same soiled fitted sheet. The state surveyor showed the soiled linen to NA K, and NA K responded the fitted sheet was dirty. NA K stated she was assigned to the Resident#102, but the hospice aide was responsible for giving Resident#102 a shower and changing his bed linen. She further stated she did not notice the dirty linen and did not know when the last time Resident#102's bed linen was changed. NA K stated the risk to Resident#102 was development of infection. Observation and interview on 11/13/24 at 01:30 PM revealed LVN F entered Resident #102's room during the observation and interview with NA K. LVN F looked at Resident#102's bed linen fitted sheet, and stated it was dirty and need to be changed. LVN F stated the staff will change Resident#102's bed linen. LVN F stated the risk to Resident#102 was development of infection, and skin issues. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 01:57 PM with Hospice Aide, she stated she was responsible for changing the linen on the days of the resident showers. The hospice Aide stated she gave a shower to Resident #102 this morning, and did not change the bed linen, because she could not find clean linen, and she looked in other Halls linen carts. The hospice Aide stated she could not recall the staff she notified. Interview on 11/13/24 at 02:05 PM with NA K and LVN F revealed, both denied been notified by the hospice Aide regarding Resident#102's bed linen not being changed after Resident#102's shower this morning. Interview on 11/13/24 at 02:19 PM with the DON revealed, he stated the hospice aides were responsible for giving residents in hospice services showers and changing the resident's linen on the shower day. DON stated not changing Resident#102's bed linen because the hospice aide could not find clean linen was not acceptable, and the hospice aide was supposed to communicate the issue with the management. The DON stated the hospice aides get training on residents' care via their agency. DON stated the risk to residents was infection, and skin issues. On 11/13/24 at 03:00 PM the facility administrator stated they do not have a policy for linen and safe clean comfortable home like. The facility did not submit a policy for linen and safe clean comfortable home like policy by the date and time of exit.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on interview and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for one (Resident #8) of 5 residents reviewed for PASARR . The facility failed to refer Resident #8, who had an active diagnosis of Post Traumautic Stress Disorder (PTSD), to the appropriate state-designated authority for Level II PASARR evaluation. This failure could affect residents with mental disorders, intellectual disabilities, or a related condition by placing them at risk for not receiving needed treatment and services that could enhance their quality of life. Findings included: Review of Resident #8's quarterly MDS assessment dated [DATE] revealed an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses to include: hypertension (elevated blood pressure), diabetes Mellitus (elevated blood sugar), anxiety, depression, and PTSD. The resident had a BIMs score of 15, indicating her cognition was intact, and required substantial/maximal assistance with ADLs. There was not a diagnosis of dementia. Review of Resident #8's Medical Diagnosis Report dated 10/22/19 revealed, Post Traumatic stress disorder. Review of Resident #8's PASARR Level 1 screen dated 09/06/19 revealed Effective date: 09/06/2019, Resident#8. MI/ID/DD : N-N-N. admitted : yes. Status date: 09/06/2019. Status: Negative PASRR (sic) Eligibility. Review of Resident#8's psychological evaluation dated 01/30/22 revealed Resident#8 was referred for psychological service in April of 2017 due to anxiety and picking at her skin, at which time she was diagnosed with adjustment disorder and PTSD. currently carries the diagnoses of F43.10 post-traumatic stress disorder . Interview on 11/13/24 at 07:58 AM. with the Administrator revealed, he stated the Social Worker and the MDS coordinator were responsible for resident record review during the resident admission and with any changes in the resident status thereafter. Interview on 11/13/24 at 08:24 AM with Social Worker revealed, she stated she was not responsible for completing the PASARR level 1. She stated the MDS coordinator was responsible for completing the PASARR level 1 and following with the residents. She stated her responsibility on admission was to do the resident code status and schedule the care plan meeting. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 09:34 AM with the MDS coordinator revealed she was responsible for the PASARR level 1. The MDS coordinator stated when a resident admits to the facility, she reviewed the resident's information documenting the admission information on the PASARR level 1. She stated if the resident had a diagnosis of Mental Illness Health, she would answer yes to the question asking if they had a diagnosis. MDS coordinator stated the LA would come to complete a PASARR level 2 to see if the resident qualifies for services. She stated Resident#8 had been living in the facility since 2016, and the PASARR level 1 done for Resident#8 on 09/06/19 was related to the facility change of ownership. She stated that the follow-up for the PASARR 1 was her responsibly, and the SW would notify her if she noticed some change in the resident diagnosis, and the MDS coordinator would report to the LA. The MDS coordinator gave examples of diagnosis that she would check yes for: Schizophrenia, bipolar disorder, psychosis, anxiety with psychosis. The MDS coordinator stated it could had been missed, because she did not know that PTSD was a diagnosis that will qualify the residents for PASARR level 2 evaluation. She stated that the follow-up for the PASARR 1 was her responsibly and the meetings were also her responsibility, if the residents qualified for services (specialized services) it would be the responsibility of the department manager to receive the orders and initiate the services. Interview on 11/13/24 at 09:50 AM with Resident #8 revealed she did not know anything about PASARR or specialized services, no one had talked to her about that. The resident said if she was entitled to something, she wanted to be able to get it. Interview on 11/13/24 at 10:05 AM with the DON revealed, he stated the MDS coordinator took care of the PASARR reports. The DON stated he did know that PTSD was a qualifying diagnosis for PASRR. The DON stated if the assessment was not completed properly, he thought the resident might not get services she needed. Record review, no date, of facility's form, Active Residents with PASARR Positive PI , did not include Resident #8. Review of the facility's policy and procedure Resident Assessment-Coordination with PASRR (sic) program implemented March 01, 2023, reflected, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs . 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review .a. A resident who exhibits behavioral, psychiatric, . symptoms . (where dementia is not the primary diagnosis).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34918 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of four residents (Resident #13) reviewed for catheter and incontinence care. 1. The facility failed to ensure NA E and CNA D maintained the foley catheter drainage bag below Resident #13's bladder during a mechanical lift transfer. 2. The facility failed to ensure CNA C did not place the urine catheter bag on the bed while performing incontinence care for Resident #13. These failures could place residents at risk for not receiving care appropriate to address their incontinence and could increase the risk of urinary tract infections. Findings included: 1. Record review of Resident #13's quarterly MDS assessment, dated 10/02/24, reflected a [AGE] year-old male with an admitted [DATE] and a re-admitted [DATE]. He had a BIMS of 9, which indicted he was moderately cognitively impaired. Resident #13 required substantial/maximum assist with ADLs and was dependent of 2 persons assist with transfers. He had an indwelling catheter and was always incontinent of bowel. Resident #13 had diagnoses which included obstructive uropathy (structural or functional hindrance of normal urine flow) and hemiplegia (paralysis that affects one side of the body). Record review of Resident #13's care plan, with a revision date of 08/29/24, reflected, The resident has 18 French (measurement of the circumference of the outer catheter tube) indwelling catheter related to obstructive uropathy .Goal .The resident will show no signs or symptoms of urinary infection through the review period .Interventions .Catheter anchor in place .Change as needed .Monitor/record/report to MD for signs and symptoms of urinary tract infection Record review of Resident #13's Order summary report, dated 11/13/24, reflected .Foley catheter care every shift and as needed . with a start date of 05/30/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 11/12/24 at 11:15 a.m. CNA C entered Resident #13's room to provide catheter care. CNA C washed hands and put on gloves. CNA C placed a towel on the floor and placed a plastic container on the floor and emptied the foley catheter drainage bag which contained approximately 150 cc of dark amber urine. CNA C emptied the container of urine, removed her gloves, and performed hand hygiene and put on clean gloves and proceeded to provide catheter care and incontinence care. CNA C unfastened the catheter drainage bag and placed in on the bed between the resident's feet. Urine was observed in the tube flowing back toward the resident. CNA C then unfastened the brief and pulled the foreskin back revealing moderate amount of white drainage around the penis head. CNA C cleaned in circular motion and then cleaned the catheter tubing from tip downward. ADON A entered Resident #13's room and performed hand hygiene and put on gloves. ADON A immediately picked up the catheter bag lying on the bed and placed it back on the bed frame ADON A and CNA C completed the incontinence care and removed their gloves and performed hand hygiene. In an interview with CNA C on 11/12/24 at 11:35 a.m. she stated the catheter bag was considered dirty and by placing it on the bed it was not below the bladder and urine could back up into the bladder. In an interview with ADON A on 11/12/24 at 11:40 a.m. he stated he walked into the room and observed the catheter bag on the bed and knew it was not supposed to be on the bed, and he instinctively stepped in and placed it in the proper place to ensure the flow of urine was not backing up toward the resident. He stated the staff were taught to always keep the urinary drainage bag below the bladder. In an observation with ADON A on 11/13/24 at 09:20 a.m. NA E and CNA D entered Resident #13's room with the Mechanical lift. Both staff washed their hands and put on gloves. Both staff maneuvered the lift around the resident's wheelchair and hooked the sling to the lift. NA E unhooked the catheter bag from the wheelchair and started to hook it to her pants legs when CNA D instructed her to hang it on the mechanical lift arm. NA E placed the catheter bag on the arm of the mechanical lift which was above the resident's bladder. The staff lifted the resident up with the catheter bag above the bladder and transferred him from the wheelchair to the bed. Staff then unhooked the urinary drainage bag and placed it on the bed frame. In an interview with ADON A on 11/13/24 at 09:30 a.m. he stated the urinary drainage bag was not supposed to be hooked to the mechanical lift during the transfer because it placed it above the bladder which could increase the risk of the urine backing up into the bladder and causing urinary tract infections. He stated he realized after the observations he had seen the past two days they needed to be observing the staff more frequently while they were providing care. He stated they had developed some bad habits and he needed to address how they were training and reinforce that training through more one-on-one observations during resident care. In an interview on 11/13/24 at 09:35 a.m. with CNA D she stated they were supposed to ensure the catheter tubing was over the resident's leg. She stated she was afraid if NA E had hooked the drainage bag to her pants it would pull the catheter too tight when they transferred Resident #13. She stated the catheter was supposed to be lower than the bladder but stated she really was not sure how they were supposed to keep it below the bladder during a mechanical lift transfer. She stated she guessed one of them should have held the catheter bag during the transfer. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/13/24 at 09:40 a.m. with NA E she stated they were supposed to always keep the catheter bag below the bladder to prevent the urine from flowing back toward the resident's bladder. She stated one of them should have held it below the bladder. In an interview with the DON on 11/13/24 at 01:00 p.m., he stated any resident with a foley catheter should always have the bag and tubing below the bladder and the bag should never be placed on the bed. He stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of a urinary tract infection and cross contamination. He stated all the staff had been trained numerous times on the expectation. He stated to ensure staff were knowledgeable in the care of indwelling catheters and peri-care the facility did skills competency checks, but stated he and ADON A had discussed they were going to have to observe staff more frequently during resident care. Record Review of CNA D's skills check off dated 10/09/24 reflected she was competent in the care of indwelling catheters and infection control. Record Review of NA E's skills check off dated 10/08/24 reflected she was competent in the care of indwelling catheters and infection control. Record review of the facility's policy titled, Perineal Care, dated May 2024, did not address foley catheter care. Record review of the facility's undated skills assessment titled, Indwelling Catheter care, reflected, Ensure that the resident has a catheter secured in placed and a privacy bag for the urine collection bag. Never lift the catheter urine bag above the resident's bladder .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34918 Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one of seven (Residents #77) residents reviewed for pharmacy services. The facility failed to ensure LVN F followed the procedure for accurate administration of Resident #77's Insulin Glargine Solution 15 unit when he held the daily dose of Insulin without notifying the physician on 11/11/24. These failures placed residents at risk of not receiving a therapeutic dosage of medication. Findings included: Record review of Resident #77's Admission MDS assessment dated [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident had a BIMS score of 3 which indicated she was severely cognitively impaired. Diagnoses included type 2 diabetes mellitus and Osteomyelitis (infection in the bone). Record Review of Resident #77's Physician Orders Report on 11/11/24 reflected, Insulin Glargine Solution 100 unit/ml (long-acting insulin that increases insulin levels in the body to help decrease blood sugar) inject 15 unit subcutaneously one time a day for diabetes related to type 2 diabetes mellitus without complications until 11/15/24 with a start date of 11/07/24. There were no parameters for when to hold the insulin. An observation of the medication pass on 11/11/24 at 10:55 a.m. revealed LVN F performed a fingerstick blood sugar on Resident #77 and obtained a reading of 113. LVN F returned to the medication cart and disposed of the lancet and test strip and placed the glucometer on top of the medication cart and stated he was holding Resident #77's Glargine Insulin because he did not want her blood sugar to bottom out. LVN F documented into the electronic medication administration record the resident's blood sugar level and documented the medication was held. In an interview with LVN F on 11/11/24 at 1:00 p.m. he stated he held Resident #77's insulin but did not notify the doctor. He stated there were no parameters for when to hold her insulin for the routine insulin, but there were parameters for the sliding scale. He stated he should have notified the physician. In an interview on 11/12/24 at 01:00 p.m. with the DON he stated anytime a medication was held that did not have specific parameters they should notify the physician. He stated holding a medication could result in the resident not receiving the therapeutic dose of medication which could worsen the resident's conditions. He stated they had followed up with the physician on 11/11/24 after becoming aware the insulin was held and they now had parameters in place for when to hold Resident #77's maintenance dose of insulin. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/13/24 at 10:15 a.m. with the facility's Pharmacy consultant, she stated missing a dose of maintenance insulin could result in not having a constant therapeutic level in the resident's system when it was every 24 hour medication. She stated they usually do not have parameters on holding maintenance insulin, but if it was held, they would need to notify the physician for orders. Record Review of Resident #77's Physician Orders Report dated 11/12/24 reflected, Insulin Glargine Solution 100 unit/ml inject 15 unit subcutaneously one time a day for diabetes related to type 2 diabetes mellitus without complications until 11/15/24 Hold for blood glucose less than 140 . with a start date of 11/11/24. Record review of LNV F's Nurse check off list dated 10/08/24 reflected he was competent in Medication administration. Record review of the facility's policy, Medication Administration, dated May 2024, reflected, Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice When applicable, hold medication for those vital signs outside the physician's prescribed parameters .Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects .Administer medication as ordered in accordance with manufacturer specifications Record review of the facility's policy, Timely Administration Insulin, dated May 2024, reflected, It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition .All insulin will be administered in accordance with physician's orders .

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49837 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: 1. The facility failed to ensure that two dented cans were removed and separated from the other canned food. 2. The facility failed to ensure that two cans of oven cleaner and two bottles of bleach were stored separately from food items in the dry storage room. 3. The facility failed to ensure the dry storage room floor was free from all items. 4. The facility failed to ensure hair restraints were worn properly during food preparation in the kitchen. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation of the dry storage room on 11/11/24 at 9:46 AM revealed two 6 lb. dented cans of apple slices mixed in with other canned foods. There were two cans of oven cleaner located on the shelf next to bottles of Worchester sauce and food coloring. There was also a box that contained two bottles of bleach and a box of cup lids that was located on the dry storage room floor. In a brief interview with Dietary Supervisor, with the Administrator present on 11/11/24 at 10:12 AM, she revealed that they had a dented' can sign next to the dented cans, but it must have fallen off. The Administrator left and returned with a dented can sign and taped it next to the dented cans located to the far right of the canned food shelf. Observation during lunch service on 11/11/24 at 11:45 AM revealed [NAME] L wore a hair restraint but had about 1/4 inch of hair out in the back and on the sides, while she scooped food onto resident's plates. Observation during lunch service on 11/11/24 at 11:45 AM revealed Dietary Aide M wore a hair restraint but had about 1/4 inch of hair out in the back and on the sides, while she plated residents' food trays. Dietary Aide N wore a hair restraint but had about 1/4 inch of hair out in the back, while she plated residents' food trays and Dietary Aide O wore a hair restraint but had exposed strands of hair, approximately six inches, on each side of her temples while she plated residents' food trays. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Dietary Aide M on 11/11/24 at 12:35 PM she revealed all hair is supposed to be covered underneath the hair restraint. She stated she was unaware any hair was out. She stated the risk to the residents was hair could fall into their drinks and food, which could cause them to choke. In an interview with [NAME] L on 11/11/24 at 12:41 PM she revealed all hair is supposed to be underneath the hairnet. She stated the risk to the residents was that the hair could fall into their food or drinks, which could cause them to choke. In an interview with Dietary Aide O on 11/11/24 at 12:43 PM she revealed hair was supposed to be fully covered underneath the hair restraint. She stated the risk to residents was hair could get into the resident's food and drinks, which could cause them to choke. In an interview with Dietary Aide N on 11/11/24 at 12:45 PM she revealed all hair is supposed to be underneath the hair restraint. She stated the risk to the residents was that hair could fall in their food and drinks, which could cause the residents to choke. In an interview with Dietary Supervisor on 11/11/24 at 12:47 PM she revealed she did not know there were dented cans mixed in with other canned food. She stated the dented cans should be stored with the other dented cans. She stated the cans of oven cleaner, and bottles of bleach should be stored in her office. She stated the cup lids should be stored on the shelf and not on the floor. She stated the risk to the residents due to these failures was contamination. She stated hair restraints are supposed to be worn over staff ears, covering all hair. She stated the risk to residents was that hair could get into the resident's food and drinks, which could cause them to choke. She stated her expectations of staff was to ensure that all hair was covered underneath the hair restraint. During an interview on 11/13/24 at 01:40 PM, the Administrator stated he expected hairnets to be worn to cover the entire head, dented cans placed in the dented can section, the floor should be free from all items and the oven cleaner, and bottles of bleach should be stored in their proper place. He stated these failures could potentially put residents at risk for cross contamination, and food borne illness. Record review of the facility policy titled 'Nutritious Lifestyle, Inc' dated 2012, revealed, All foods delivered are examined and foods that appear contaminated or have damage to the packaging are rejected, including any cans with swollen ends, leaks and flawed seals, rust and dents or containing no label. Dented cans or any item with damaged packaging is separated and kept in a separate designated area. Items are returned to the supplier on next delivery and a credit is requested. Record review of the facility policy titled 'Nutritious Lifestyle, Inc' dated 2012, revealed, Cleaning materials or other chemicals are not used or stored where they might contaminate foods. Chemicals are labeled and kept in their original containers when possible and stored in a locked area away from any food products. Record review of the facility policy titled 'Nutritious Lifestyle, Inc' dated 2012, revealed, Hairnets, headbands, caps, or other effective hair restraints shall be worn to keep hair from food and food-contact surfaces. (continued on next page)

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Pecan Tree Rehab and Healthcare Center	1900 E California St Gainesville, TX 76240

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled 'Nutritious Lifestyle, Inc' dated 2012, revealed, All items are stored at least 6 above the floor with adequate space between the items and the ceiling to allow for air flow and sprinkler system operation. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, 2-402.11, revealed, (A) Except as provided in (B) of this section, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles.

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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** 34918 Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four of 19 residents (Resident #77, Resident #15, Resident #13, and Resident #68) observed for infection control. 1. The facility failed to ensure LVN F used the required PPE for Resident #77, who was on enhanced barrier precautions due to her venous access device, while administering resident IV antibiotics on 11/11/24. 2. The facility failed to ensure that CNA B performed hand hygiene before moving to the clean supplies after completion of incontinence care to Resident #15 and before leaving the resident's room on 11/12/24. 3. The facility failed to ensure that CNA C and ADON A used the required PPE for Resident #13 who was on enhanced barrier precautions due to his foley catheter, while providing catheter and incontinence care on 11/12/24. 4. The facility failed to ensure CNA D and NA E used the required PPE for Resident #13, who was on enhanced barrier precautions due to his foley catheter, while performing a mechanical lift transfer on 11/13/24. 5. The facility failed to ensure CNA G performed hand hygiene while providing incontinence care to Resident #68 on 11/11/24. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #77's Admission MDS assessment dated [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident had a BIMS score of 3 which indicated she was severely cognitively impaired. Diagnoses included type 2 diabetes mellitus and Osteomyelitis (infection in the bone). Record Review of Resident #77's Physician Orders Report on 11/11/24 reflected, Resident requires EBP Related to PICC line (a long, flexible tube that is inserted into a vein in the arm and used to deliver medications) until Discontinued every shift with a start date of 11/04/24. Record review of Resident #77's comprehensive care plan initiated on 10/23/24, reflected, Resident is on Enhanced Barrier Precautions related to PICC line .Interventions .Apply appropriate PPE during all High-Contact resident care activities . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the medication pass on 11/11/24 at 10:55 a.m. revealed LVN F at the medication cart preparing Resident #77's intravenous antibiotic and gathering supplies needed for fingerstick blood sugar. LVN F entered Resident #77's room, performed hand hygiene and put on gloves, but did not put on a gown. LVN F cleaned the PICC line lumen (access line) with an alcohol wipe and flushed the PICC line with 10 cc of Normal Saline. LVN F then connected the IV line to the PICC line for the medication administration. LVN F then performed a fingerstick blood sugar on Resident #77 and obtained a reading of 113. LVN F returned to the medication cart and disposed of the lancet and test strip and removed his gloves and performed hand hygiene. He stated the IV would run about 30 minutes to an hour. A second observation on 11/11/24 at 12:15 p.m. revealed LVN F entering Resident #77's room to disconnect the IV infusion. LVN F performed hand hygiene and put on gloves, but no gown. LVN F disconnected the IV line from the resident's PICC line and flushed the PICC line with 10 cc of normal saline. LVN F removed his gloves and performed hand hygiene. In an interview with LVN F on 11/11/24 at 1:00 p.m. he stated Resident #77 was on Enhanced Barrier Precautions because of her IV access line. He stated he was supposed to wear a gown and gloves while providing care or medication administration to her PICC line and failed to do so. He stated he just forgot. He stated he had been in serviced on the use of Enhanced Barrier Precautions and what PPE was required. 2. Record review of Resident #15's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female with an admitted [DATE]. The resident had a BIMS of 15 which indicated she was cognitively intact. She required substantial to maximum assistance with toileting and transfers and was always incontinent of bladder and bowel. Diagnoses included hypertension (high blood pressure), diabetes, and a personal history of urinary tract infections. In an observation on 11/12/24 at 10:20 a.m. CNA B and ADON A entered Resident #15's room to provide a mechanical lift transfer and incontinence care. Both staff washed their hands and put on gloves and hooked the mechanical lift sling onto the lift and transferred the resident from her wheelchair to the bed. Both staff pulled the resident's pants down and unfastened the brief. CNA B wiped from front to back changing the wipes with each swipe. Without changing her gloves and performing hand hygiene, CNA B then reached into the plastic bag to retrieve the clean brief and laid it on the bed next to the resident. ADON A prompted her she needed to complete the peri care and both staff rolled the resident on her side revealing she had a small bowel movement. CNA B wiped from front to back and went to reach for the brief, when ADON A stopped her and told her to change her gloves. CNA B removed her gloves and then ADON A handed her a bottle of hand sanitizer and prompted her to sanitize her hands before putting on her gloves. CNA B sanitized her hands and put on gloves and then placed the brief on the resident and both staff pulled the resident's pants back up. Resident stated she wanted to get back up for lunch. CNA B removed her gloves and left the room without performing hand hygiene to retrieve the mechanical lift. CNA B returned to the room and washed her hands and put on gloves. ADON A removed his gloves and washed his hands and re-gloved. Both staff transferred the resident back to her wheelchair. ADON A positioned the resident and returned her overbed table in front of her, placed her call light within reach and went to the bathroom to wash his hands. CNA B gathered the dirty linens and trash and removed her gloves and left the room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/12/24 at 10:55 a.m. with the ADON A he stated the CNA B contaminated the clean brief when she reached into the bag and retrieved the brief before she had completed the peri-care. He stated he had to prompt her to change her gloves when she finished with the incontinence care before placing the clean brief on her. He stated the staff were to always perform glove changes and hand hygiene when going from dirty to clean. He stated they were to always wash their hands before leaving the resident's room if they had contact with the resident. He stated failing to do this placed resident at risk of infections and cross contamination. In an interview with CNA B on 11/12/24 at 11:00 a.m. she stated she thought she had performed hand hygiene when she left the room, but stated she may have forgotten. She stated she realized she had contaminated the brief and should have completed the care before moving to the clean brief. She stated she had received training on incontinent care but stated she was a new CNA and had trouble remembering some of the steps. 3. Record review of Resident #13's quarterly MDS assessment, dated 10/02/24, reflected a [AGE] year-old male with an admitted [DATE] and a re-admitted [DATE]. He had a BIMS of 9, which indicted he was moderately cognitively impaired. Resident #13 required substantial/maximum assist with ADLs and was dependent of 2 persons assist with transfers. He had an indwelling catheter and was always incontinent of bowel. Resident #13 had diagnoses which included obstructive uropathy (structural or functional hindrance of normal urine flow) and hemiplegia (paralysis that affects one side of the body). Record review of Resident #13's care plan, with a revision date of 08/19/24, reflected, The resident requires Enhance Barrier Precautions related to foley catheter .Interventions .Follow protocol for Enhanced Barrier Precautions . In an observation on 11/12/24 at 11:15 a.m. CNA C entered Resident #13's room to provide catheter care. CNA C washed hands and put on gloves but did not put on a gown. CNA C placed a towel on the floor and placed a plastic container on the floor and emptied the foley catheter drainage bag which contained approximately 150 cc of dark amber urine. Resident #13 was partially uncovered and observed resident had a loose stool that had leaked out of brief onto the sheets. CNA C emptied the container of urine, removed her gloves, and performed hand hygiene and put on clean gloves and proceeded to provide catheter care and incontinence care. CNA C unfastened the catheter drainage bag and placed in on the bed between the resident's feet. CNA C then unfastened the brief and pulled the foreskin back revealing moderate amount of white drainage around the penis head. CNA C cleaned in circular motion and then cleaned the catheter tubing from tip downward. CNA C then rolled the resident over and cleaned large soft bowel movement. ADON A entered Resident #13's room and performed hand hygiene and put on gloves but no gown. ADON A then removed the soiled linen and brief, changed his gloves, and performed hand hygiene and put on clean gloves. ADON A then applied barrier cream to the Resident buttocks. ADON A and CNA C completed the incontinence care and removed their gloves and performed hand hygiene. In an interview with CNA C on 11/12/24 at 11:35 a.m. she stated residents who had foley catheters were under enhanced barrier precautions and she was supposed to put a gown on when doing catheter care. She stated she just forgot to put on the gown. In an interview with ADON A on 11/12/24 at 11:40 a.m. he stated he should have put on gown before he started assisting with care for Resident #13. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. In an observation with ADON A on 11/13/24 at 09:20 a.m. NA E and CNA D entered Resident #13's room with the Mechanical lift. Both staff washed their hands and put on gloves, but no gown. Both staff maneuvered the lift around the resident's wheelchair and hooked the sling to the lift. NA E unhooked the catheter bag from the wheelchair and started to hook it to her pants legs when CNA D instructed her to hang it on the mechanical lift arm. NA E placed the catheter bag on the arm of the mechanical lift. The staff lifted the resident up with the catheter bag and transferred him from the wheelchair to the bed. Staff then unhooked the urinary drainage bag and placed it on the bed frame. In an interview with ADON A on 11/13/24 at 09:30 a.m. he stated he realized after the observations he had seen the past two days they needed to be observing the staff more frequently while they were providing care. He stated they had developed some bad habits and he needed to address how they were training and reinforce that training through more one-on-one observations during resident care. He stated any resident with a foley catheter, or IV access line was always placed on enhanced barrier precaution. He stated he had in serviced the staff on the expectation. He stated he did not understand how they could not be following the protocol. In an interview on 11/13/24 at 09:35 a.m. with CNA D she stated they were supposed to put a gown for any care on Resident #15 because of the catheter. She stated she just forgot. In an interview on 11/13/24 at 09:40 a.m. with NA E she stated they were supposed wear a gown when doing care on Resident #13 because of the catheter. She stated they just did not think to put one on when they went in to put him in bed. She stated the risk was the spread of infection. In an interview with the DON on 11/13/24 at 01:00 p.m., he stated there had been a lot of confusion about the implementation of Enhanced Barrier Precautions on when it should be used. He stated they had in serviced the staff that for anyone with a catheter or PICC line they were required to wear a gown when performing direct care. He stated the risk was potential spread of multi-drug resistant organism from resident to resident. 5. Record review of Resident #68's quarterly MDS assessment dated [DATE] reflected she was an [AGE] year-old-female originally admitted to the facility on [DATE] and readmitted on [DATE]. Her BIMS score was 15 of 15 reflecting she was cognitively intact, required extensive, one-person assistance for ADLs and was always incontinent of bowel and bladder. Her active diagnoses included hypertension (elevated blood pressure), diabetes mellitus (elevated blood sugar), weakness, and morbid (severe) obesity due to excess calories. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/11/24 at 11:05 a.m. revealed CNA G at Resident #68's bed side, wearing gown, and gloves. CNA G unfastened Resident#68's brief, and cleaned the resident's front area, using one wipe per stroke, front to back. CNA G helped Resident#68 turn to her left side revealing Resident had a bowel movement. CNA G cleaned the resident's buttocks area front to back using one wipe per stroke. CNA G removed the dirty brief, disposed of it in the trash can by the bed side, put a clean brief next to resident and then removed her gloves and put on clean gloves without performing hand hygiene. CNA G then applied barrier cream to the resident's buttocks area, put the brief under and turned the resident onto her back. She then applied barrier cream on Resident#68's front area. CNA G finished putting the brief on Resident#68 and fastened the brief. CNA G removed gloves, retrieved a disposable under pad and then put on clean gloves without performing hand hygiene, placed the under pad under the resident and adjusted the pillows under the resident's leg. CNA G covered Resident#68 and removed her gloves and gown and disposed of them in the trash bag. CNA G took the trash bag and disposed of it in a hamper in front of the room and returned to the resident's room and washed hands. In an Interview on 11/11/24 at 12:14 p.m. with CNA G she stated she knew she was supposed to perform hand hygiene between glove changes. CNA G stated she was supposed to have hand sanitizer with her, but stated she was gowned, and did not have one in the room. CNA G stated the risk to resident was cross contamination. She stated had been in serviced on hand hygiene a month ago. In an interview on 11/12/24 at 01:00 p.m. with DON he stated staff were supposed to wash hands and change gloves before, and after completion of cleaning a resident and after completion of care. He stated they had worked so hard with the staff on skills and stated they were all aware of what they were supposed to be doing. He stated the risk of failing to perform hand hygiene was increased infections and cross contamination. Record Review of LVN F's Nurse check off dated 10/08/24 reflected he was competent in infection control and the use of Personal Protective equipment. Record Review of CNA D's skills check off dated 10/09/24 reflected she was competent in the care of indwelling catheters, infection control and the use of Personal Protective equipment. Record Review of NA E's skills check off dated 10/08/24 reflected she was competent in the care of indwelling catheters, infection control and the use of Personal Protective equipment. Record Review of CNA B's skills check off dated 10/08/24 reflected she was competent in infection control and the use of Personal Protective equipment. Record Review of CNA C's skills check off dated 10/07/24 reflected she was competent in infection control and the use of Personal Protective equipment. Record Review of CNA G's skills check off dated 10/08/24 reflected she was competent in infection control and the use of Personal Protective equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Enhanced Barrier Precautions, dated May 2024, reflected, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . Enhanced Barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .An order for enhanced barrier precautions will be obtained for residents with any of the following .urinary catheters .PICC lines .High contact resident care activities include Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Device care or use: central lines, urinary catheters .PICC lines . Record review of the facility's policy titled, Hand Hygiene, dated June 2024, reflected, .2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . When, during resident care, moving from a contaminated body site to a clean body site .6. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . 47690