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	02/18/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents receive care consistent with professional standards of practice based on the comprehensive assessment for two (Resident #5 and Resident #75) of nine residents reviewed for pressure ulcers.The facility failed to ensure Resident #5, and Resident #75 were provided with a weekly skin assessment that reviewed total body skin surfaces with accurate clinical documentation of skin integrity. This oversight resulted in the development of skin injuries that were undocumented and untreated. The facility nursing staff failed to identify, document, or notify the primary physician for appropriate treatment and services.This failure could place all residents at risk of developing skin injuries and not receive appropriate treatment and services that affect quality of care and quality of life. Findings include: Record review of face sheet dated 02.16.26 for Resident #5 revealed a [AGE] year-old-male admitted to the facility on 12.16.2025. Diagnoses: acute cystitis (urinary bladder infection) with hematuria (blood in urine), type two diabetes mellitus, severe protein/calorie malnutrition, major depressive disorder, (severe depression), and encephalopathy (brain disorder causing confusion and memory loss). Record review of MDS dated 01.20.2026 revealed a BIMS score of 15 indicated intact cognition. Section GG - functional abilities revealed the resident required extensive assistance of two staff with activities of daily living. Section I - active diagnosis revealed medically complex conditions. Section M - skin conditions revealed no pressure injuries, arterial or venous ulcers. Record review of comprehensive care plan dated 01.18.2026 revealed Resident #5 required extensive assistance with ADLs due to immobility and joint contracture. The resident required transfers by a mechanical lift with assistance of two CNAs. The resident was at risk of skin integrity due to medically complex conditions. During interview and observation on 02.16.2026 at 1:00 PM Resident #5 was transferred by Hoyer lift from his bed to a shower chair by CNA A and CNA B. During the transfer the residents' feet were observed to be bare. A 1cm by 1cm by 0.5 cm deep round black area was observed on the ball of the resident's left foot without a bandage present. CNA A and CNA B stated they were unaware of the skin issue identified. Both CNAs were asked what the expectation was for identifying new skin issues during the process of showering residents. CNA A, who had worked at the facility for five years, stated new skin issues identified during showering residents were reported to the charge nurse immediately. CNA B stated she had worked at this facility for five months and was still learning policy and procedure. Record review of skin assessments for Resident #5 dated 01.08.2026, 01.20.2026, 01.27.2026, 02.13.2026 revealed no documentation related to the identified skin injury to the ball of the left foot. Interview with CNA A on 02.17.26 at 9:10 AM revealed she did not notify the charge nurse of the skin issue identified to the ball of the left foot for Resident #5 on 02.16.26. She stated she meant to notify, but she got busy and forgot. Interview with CNA B on 02.17.26 at 9:13 AM revealed she did not notify the charge nurse of the skin issue identified to the ball of the left foot for Resident #5 as she forgot about the conversation. Interview on 02.17.2026 at 9:15 AM with LVN E revealed he has worked at this facility for eight years. He was the charge nurse for Resident #5 on the 6:00 AM to 2:00 PM shift, Monday through Friday. He stated he was unaware of a skin injury to the ball of the left foot for Resident #5. LVN E stated the CNAs were the first-line staff to do skin assessments while (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performing personal care or showers for residents. He stated the CNA reports skin changes to the charge nurse; the charge nurse makes an assessment then fills out a skin report worksheet and gives it to the treatment nurse. The treatment nurse calls the physician and gets a treatment order and starts treatment and documentation. Interview and observation on 02.17.2026 at 9:30 AM with the facility treatment nurse revealed she had worked at this facility since June 2024. She stated she was unaware of a new skin injury for Resident #5. She was observed to go to Resident #5 and perform a skin assessment and confirmed she was unaware of the change in skin condition. The resident was asked if he was aware of the change in his skin on his left foot. He stated he was unaware and became visibly and verbally upset. Interview on 02.17.2026 at 9:45 AM with LVN E revealed weekly skin assessments are divided between 6:00 AM to 2:00 PM nurses and the 2:00 PM to 10:00 PM nurses. The same nurses perform the same resident skin assessments for continuity of care. The expectation was that CNAs look at all skin surfaces while showering residents. If a change in skin is observed the CNA reports to the charge nurse who performs a skin assessment and documentation is sent to the facility treatment nurse. Interview and observation on 02.17.2026 at 10:00 AM with treatment nurse revealed she performed head-to-toe skin assessments quarterly on residents with no identified skin issues. She assessed residents with known wounds weekly accompanied by the wound care physician. Record review of Resident #75's face sheet dated 02.17.2026 revealed a [AGE] year-old-male admitted to the facility on 05.23.2024 with the following diagnoses: COPD (lung disease causing difficult breathing), Alzheimer's disease, dysphagia (difficult swallowing), major depressive disorder (depression), and type two diabetes mellitus. Record review for Resident #75 of MDS dated 12.13.2025 revealed the resident had a BIMS score of 3 that indicated severe cognitive impairment. Section GG - functional abilities revealed the resident requires extensive assistance from two staff for activities of daily living. Section M - skin condition revealed no documented pressure injuries, arterial or venous ulcers. Record review of comprehensive care plan for Resident #75 revealed resident had a deficit in self-care performance and activity intolerance due to limited range of motion of upper and lower extremities. Interview and observation on 02.17.2026 at 11:30 AM with LVN C and CNA D revealed during a skin assessment for Resident #75 they were unaware of a change in the skin on the second and third toes on the resident's right foot. 1 cm by 1cm by 0 cm areas on both toes were observed to be black with redness surrounding the black areas. Record review for Resident #75?sr weekly skin assessments dated 01.09.2026, 01.26.2026, 02.09.2026, and 02.16.2026 all revealed no documentation for a change in skin condition to the second and third toes on the right foot. Interview on 02.17.2026 at 1:35 PM with Director of Nurses revealed several changes that had occurred with the new administration. She stated there was no policy for the shower or skin worksheets used previously, and they were no longer being used as of this week. Her expectations were for CNAs to verbally tell charge nurses about changes in skin condition for residents instead of using worksheets. The expectation now was after the CNA tells the charge nurse of a change in skin condition; the charge nurse was responsible for doing a skin assessment. If a wound was identified, the wound care vendor was notified. The wound care physician assumes treatment care. The wound care physician visits the facility weekly and reviews wound care with the facility treatment nurse. The charge nurses document weekly skin assessments in the electronic clinical record. The DON stated the CNAs are the front-line staff performing skin assessments while providing routine skin care during personal care or showers. The charge nurses are responsible for notifying the physician and family of a change in resident condition. She stated if skin issues are not recognized in time to prevent further injury, a self-report to the State will be made. Telephone interview on 02.17.2026 at 2:46 PM with the facility medical director revealed his expectations for the facility nursing staff related to reporting skin issues was for him to be notified as soon as possible. He stated many times he was not notified by the facility nursing staff because they notified the wound care vendor first. He stated his consultation was needed before calling the wound care vendor. He stated he was the primary care provider for Residents #5 and #75 and unaware of any change in skin condition for these (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. Review of Skin Monitoring: Comprehensive CNA Shower Review worksheets for Resident #5 for dates: 01.30.2026, 02.02.2026, 02.04.2026, 02.06.2026, 02.09.2026, 02.11.2026, 02.13.2026, and 02.16.2026 revealed no documentation of skin change on the ball of the resident's left foot. The worksheets were signed by the CNA providing care and the Charge Nurse. Review of Skin Monitoring: Comprehensive CNA Shower Review worksheets for Resident #75 on for dates: 01.30.2026, 02.02.2026, 02.04.2026, 02.06.2026, 02.09.2026, and 02.16.2026 revealed no documentation of skin change on the second and third toes of the resident's right foot. The worksheets were signed by the CNA providing care and the Charge Nurse. Record review of podiatry notes dated 01.15.2026 for resident #75 revealed no documentation or recommendation of treatment to the second and third toes of the resident's right foot. Telephone interview with Wound Care Physician on 02.18.26 at 10:30 a.m. revealed she had been notified by the facility on 02.17.2026 at 5:30 PM of two residents that had skin issues. The physician stated that telehealth visits were conducted for Residents #5 and #75. She stated residents with diabetes have circulatory problems, and she will not know what stage of pressure ulcer was below the dead black skin until it was surgically removed. With removal of the dead skin tissue the injury can be determined at stage one, two, three, or four. She stated the skin injuries for Resident #5 and Resident #75 are considered unavoidable due to the medical conditions of the residents. Interview with Director of Social Services on 02.18.26 at 10:50 AM. she stated the facility used a vendor for podiatry care for all diabetic residents. She stated the CNAs and Nurses are the front-line staff that assess skin and reports problems. When a foot issue is identified for a diabetic resident, Social Services is notified, and she contacts the vendor and makes the appointment for the resident to be seen. The Podiatrist comes to the facility and provides care. After care, the podiatrist sends an email with care notes, treatments provided, and any orders or treatments required. This document is scanned into Point Click Care for the resident record. The DON and administrator are cc'd on this email. Interview on 02.18.2026 at 11:30 AM with LVN E revealed when the podiatrist sees a resident, the charge nurse should check the documentation and make a skin treatment communication sheet that is passed to the treatment nurse. Interview on 02.18.2026 at 11:35 AM with treatment nurse revealed the skin treatment communication sheet is no longer in use at this facility. The expectation is that all communication between CNAs and nurses be verbal instead of using worksheets. Record review for resident #75 on 02.18.2026 at 12:00 PM revealed a skin assessment note dated 02.17.2026 at 11:51 AM had documentation strikes and new documentation entered that replaced original assessment. Record review for resident #5 on 02.18.2026 at 1:00 PM revealed a skin assessment note dated 02.17.2026 at 9:53 AM had documentation strikes and new documentation entered that replaced original assessment. Review of facility Foot Care policy, undated, revealed the goals for foot management: The resident will maintain intact skin integrity The resident will be free from infection The resident will remain free from injury to the feet Procedure: Become familiar with medical conditions that compromise circulation in the feet and assess for need of nail trimming Daily assessment of the feet should be done when care is given Record review of facility policy dated 08.12.2016 for Pressure Injury: Prevention, Assessment and Treatment revealed: Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse. The treatment nurse will: Notify the physician of pressure sore and obtain and follow any orders as directed by the physician Notify family and dietary department. Document Notification Director of Nursing or designee to in-service nurses and CNAs on prevention

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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. Based on observations, interviews and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen. The facility failed to ensure food items were properly stored in the facility kitchen on 02/18/26. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness and food contamination.Findings included: Observation on 02/18/26 at 9:10 AM of the refrigerator in the kitchen area revealed a tray containing six uncovered pies on the middle shelf placed on top of a container full of 3 packages of raw frozen chicken. An interview with the Dietary Manager on 02/18/2026 9:23 AM revealed raw foods should be placed on the bottom rack in case it leaks to avoid contamination. The Dietary Manager stated the pies should have been covered to avoid anything getting on them and to avoid contamination. The Dietary Manager stated kitchen staff completed food handlers training within the first 30 days of hire. The Dietary Manager stated kitchen staff was last in-serviced on food storage procedures 6 months ago. An interview with the Dietary Aide on 02/18/26 at 1:14 PM revealed she placed the pies on top of the container of chicken. She stated the pies were uncovered and she didn't think about it. She stated the pies should have been covered to prevent cross contamination and to prevent anything from falling on them. She stated residents could get sick from cross contamination. An interview with the Dietary [NAME] on 02/18/26 at 1:23 PM revealed she placed three bags of chicken on the middle shelf of the refrigerator the night prior because there was not room on the bottom shelf. She stated it was important to place raw meat on the bottom shelf in case it leaked, it would cause cross contamination. Review of the facility's policy titled Dietary Services Policy and Procedure manual 2012 reflected, .Frozen items that should be thawed before preparation should be stored under refrigeration until thawed. The U.S. Food and Drug Administration reflected the following, . Keep foods covered: Store refrigerated foods in covered containers or sealed storage bags, and check leftovers daily for spoilage. The Centers for Disease Control and Prevention Food Safety, dated April 2024, reflected the following, .In the refrigerator: Keep your chicken stored on the bottom shelf of the refrigerator in a sealed container or wrapped securely so the juice doesn't leak onto other foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 4 of 8 residents (Resident #42, Resident #53, Resident #76, and Resident#5) observed for infection control. 1-The facility failed to ensure LVN B sanitized the blood pressure cuff (a reusable equipment) between residents (Resident#53, and Resident#76) use on 02/17/2026. 2-The facility failed to ensure CNA A performed hand hygiene while providing incontinent care to Resident #42 on 02/17/2026. 3-The facility failed to ensure CNA A and CNA B performed hands hygiene while performing Resident#5 mechanical transfer from bed to a shower chair on 02/16/26 These failures could place residents at risk for development of infection. 1-Record review of Resident #76's Doctor's orders summary dated 09/03/2024 and still active on 02/17/2026 revealed Metoprolol Tartrate tablet give 12.5 mg by mouth two times a day related to essential (primary) hypertension hold for SBP less than 110, DBP less than 60, pulse less than 60. Recorder review of Resident #53's Doctor's orders summary dated 01/02/2026 and still active on 02/17/2026 revealed Losartan potassium oral tablet 25 mg give 1 tablet by mouth one time a day related to essential (primary) hypertension hold for SBP less than 100. Observation on 02/17/26 at 07:56 AM, reflected LVN B checked Resident #76's blood pressure, and put the blood pressure cuff on top of the medications cart, she prepared the morning medications and gave it to Resident #76 using proper hand hygiene. LVN B used the same blood pressure cuff without sanitizing it, checked Resident #53's blood pressure and put it on the top of the medications cart. In an interview on 02/17/26 at 08:10 AM, LVN B stated she sanitized the blood pressure cuff sometimes but not every time she used it between residents. When asked about the facility policy on sanitizing the reusable equipment between residents, she replied she was supposed to sanitize the blood pressure cuff each time she used it and before using it on another resident. LVN B stated the risk of not following proper sanitization of the reusable equipment was cross contamination and development of infection for the residents. 2-Record review of Resident #42's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old male admitted to the facility on [DATE], and readmitted [DATE] with the diagnoses of hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), and cerebrovascular accident (occurs when blood flow to the brain is interrupted, leading to brain damage). Resident #42 had a BIMS score of 07, which indicated severe cognition impairment. Further review revealed urinary continence/ bowel continence were coded as frequently incontinent. Record review of Resident #42's care plan dated 12/17/25 reflected, focus: the Resident have an ADL Self Care Performance Deficit r/t stroke, impaired balance Goal: the Resident will maintain current level of function /minimize decline through the review date. Intervention/Tasks: toilet use: the Resident needs assistance from staff.[sic] Observation on 02/17/26 at 08:52 AM, reflected CNA A entered Resident #42's room washed hands, put on clean gloves and explained to the resident that she was to provide incontinent care. CNA A positioned the resident and unfastened his brief, then proceeded to clean the resident. Resident#42's brief was soaked with urine. CNA A cleaned Resident #42's front area, removed gloves, and put on clean gloves without performing any form (hands sanitizing of hands washing) of hand hygiene. CNA A helped Resident #42 turn to his left side. CNA A removed the dirty brief, put it in the trash can, changed gloves without performing any form of hand hygiene. When CNA A completed cleaning Resident #42's buttocks area, she applied the clean brief on Resident #42 without changing gloves. CNA A removed gloves, covered the resident, and moved the bedside table closer to the resident. After care, CNA A completed hand hygiene and exited the room. In an interview on 02/17/26 at 09:05 AM, CNA A stated she was to complete hand hygiene before and after care and after taking off Resident #42's dirty brief. CNA A stated she was supposed to change her gloves with hand hygiene after she cleaned the resident before applying the clean brief. CNA A stated she was supposed to sanitize her hands each time she removed the dirty gloves before putting on the clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves, but she forgot to bring hand sanitizer with her. CNA A stated not following proper hand hygiene and infection control policy could lead to cross contamination and development of infection for residents. In an interview on 09/25/25 at 2:40 PM, the DON stated infection control was important during care. The DON stated during care the staff was to use hand sanitizer or wash hands if they were physically soiled. The DON stated the staff was expected to complete hand hygiene before care and after care, he also stated during incontinent care the staff was supposed to change gloves and use hand sanitizer when taking off the dirty brief before applying the clean brief. The DON stated proper hand hygiene and following proper infection control was to be followed to prevent the development infections for residents and staff. 3-During interview and observation on 02.16.2026 at 1:00 PM Resident #5 was transferred by Hoyer lift from his bed to a shower chair by CNA A who has worked at this facility for five years; and CNA B who has worked at this facility for five months. Both CNAs were observed to put on PPE. The gowns were put on correctly. The first set of gloves were put on without hand hygiene. Both CNAs were observed to change their gloves four times each without performing hand hygiene between glove change while transferring Resident #5 by Hoyer lift from his bed to the shower chair Resident #5 was observed to be on enhanced barrier precautions.MDS record review on 02.16.26 at 1:13 PM Resident #5 - BIMS score 15 reflected the resident could be interviewed. Section GG states resident requires moderate assistance for ADLs. No skin issues noted in the current MDS. Resident is on enhanced barrier precautions for a supra-pubic urinary catheter.Record review on 02.16.2026 at 1:30 PM of comprehensive care plan dated 01.18.2026 revealed Resident #5 required extensive assistance with ADLs due to immobility and joint contracture. The resident requires transfers by Hoyer lift with assistance of two CNAs. The resident was at risk of skin integrity due to medically complex conditionsOn 02.16.26 at 2:45 PM a review of Infection Control Policy dated 3.2024 revealed: Infection Control Policy/Procedure The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility will establish an Infection Control Program under which it - Investigates, controls, and prevents infections in the facility. Decides what procedures, such as isolation, should be applied to an individual resident; and Maintains a record of incidents and corrective actions related to infections. Facility Assessment / Infection Prevention and Control Assessment Tool for Long-term Care Facilities At least annually and on an as-needed basis the facility will conduct a facility-wide assessment to determine the resources needed to maintain an efficient and up-to-date infection control program. Review of the facility Infection control Plan: Overview updated 03/2024 revealed .6. Resident care equipment and articles Non-invasive resident care equipment is cleaned daily or as needed between use by the nursing Assistant Equipment that is visibly soiled with blood or body fluids will be cleaned immediately with an approved disinfectant by the nursing assistant. A documentation system will be maintained of the cleaning. Review of the facility policy undated and titled Hand Hygiene reflected, Hand hygiene continues to be the primary means of preventing the transmission of infection. When to perform hand hygiene .Gloving: Gloves are worn for three important reasons:1 To provide protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and nonintact skin. The wearing of gloves in specified circumstances will reduce the risk of exposures to blood-borne pathogens and is mandatory for all employees. 2 To reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident-care procedures that involvetouching a resident's mucous membranes and nonintact skin. 3 To reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite can transmit these microorganisms to another resident; in this situation, gloves must be changed between resident contacts, and hands washedafter gloves are removed. Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves. Failure to change gloves between resident contacts is an infection control hazard.