STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455944	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Clarksville	2407 West Main Street Clarksville, TX 75426

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 1 of 2 residents (Resident #13) reviewed for accident hazards. The facility failed to ensure the cigarettes for Resident #13 were properly secured in the designated locked box behind the nurse's station. The facility failed to ensure Resident #13 was smoking with supervision when she was found outside in the smoking area on 12/04/24 smoking alone. These failures could place residents at risk for injuries. Findings included: Record review of Resident #13's face sheet dated 12/4/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses hemiplegia following a cerebral infarction (a stroke that causes one sided weakness or paralysis), diabetes mellitus (disease in which the body has difficulty controlling the blood sugar), depression, high blood pressure, and lack of coordination. Record review of Resident #13's admission MDS assessment dated [DATE] indicated she was able to make herself understood and was able to understand others. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact, and she was a current tobacco user. Record review of Resident #13's care plan dated 11/11/2024 indicated she was a smoker and she would have supervised smoking privileges to minimize safety risks with interventions for Resident #13 to keep all lighters/matches with facility staff for safety and she would participate in supervised smoke breaks. Record review of Resident #13's safe smoking assessment dated [DATE] indicated she should be supervised as per facility policy and all smoking equipment would be left at the nursing station in a box. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/4/24 at 09:18 AM Resident #13 was found by surveyor outside in the designated smoking area alone smoking with a lit cigarette in her hand. Resident #13 said the staff were supposed to keep the cigarettes and lighters in a box at the nurse's station. She refused to tell surveyor who gave her the cigarette she had in her hand, nor would she tell who lit the cigarette. She said usually the staff would stay out there in the smoking area with the residents when they would smoke but she guessed the staff did not stay because she was smoking at a different time. During an interview on 12/04/24 at 04:20 PM The DON said when she went outside with Resident #13, Resident #13 had her cigarettes in her pocket. She said the resident handed her the cigarettes and refused to tell her who gave her the cigarettes. The DON said all the staff were responsible for ensuring the resident did not have smoking items on them and did not smoke at undesignated time, or unsupervised. She said the failure placed Resident #13 at risk of burns, safety risks, or respiratory problems. The DON said she had her sign a sheet saying she did not abide by the policy since this was her first time violating the rules. During an interview on 12/04/24 at 05:08 PM The Administrator said Resident #13 went out on pass with friends and family and she could not be 100% sure that she wouldn't have cigarettes. She said her expectation was for all smoking items to be in a locked box at the nursing station and she expected all the residents to turn the cigarettes and lighters in to be placed in the lock box when they would get them from outside of the facility. The Administrator said the failure placed a risk of Resident #13 not following the smoking policy. Record review of the undated facility policy Smoking Policy indicated: It is the policy of this community to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. 1. Smoking by residents is allowed outside in a designated, marked smoking areas .6. Residents will not be allowed to possess any lighters, cigarettes or other smoking material. 7. IDT will develop an individualized plan for safe storage, use of smoking materials, assistance and required supervision for residents who smoke .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 19 residents reviewed for medication storage. (Resident #14). The facility failed to ensure Resident #14's vagisil maximum strength cream (used for vaginal itching), preparation H hemorrhoidal ointment (used for relief of swelling, burning, or pain from hemorrhoids), Asper creme lidocaine roll on (used for pain), fluticasone 50mcg nasal spray (used for allergies), and 2 bottles of Systane eye drops were stored and locked in an area not accessible to unauthorized staff, residents, or visitors. These failures could place residents at risk of injury. Findings included: Record review of Resident #14's face sheet dated 12/04/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses high blood pressure, arthritis, seasonal allergies, and abnormal posture. Record review of Resident #14's admission MDS assessment dated [DATE] indicated she was able to make herself understood and able to understand others. The MDS also indicated she had a BIMS score of 14 which meant she was cognitively intact. Record review of Resident #14's care plan dated 09/26/24 indicated her discharge had been determined to not be feasible based on resident and family request and need for ADL assistance and assistance with medication administration. The care plan also indicated Resident had impaired visual functioning and was at risk for a decrease in ADLs and injuries and she wears glasses with interventions for the staff to administer Systane eye drops at night. Record review of Resident #14's electronic medical record did not indicate Resident #14 had a self-administration assessment. Record review of Resident #14's order summary report dated 12/04/24 indicated she had orders for: 1. Systane Ophthalmic Solution 0.4-0.3 % (Polyethylene Glycol-Propylene Glycol (Ophth)) Instill 1 drop in both eyes at bedtime for Burning &irritation with a start date of 08/31/2024. The order summary did not indicate Resident #14 had an order for vagisil maximum strength cream, preparation H hemorrhoidal ointment, fluticasone nasal spray, nor asper creme lidocaine pain roll on. During an observation on 12/02/24 at 11:50 AM Resident #14 was sitting in her room in her wheelchair and had a bottle of fluticasone 50mcg allergy relief nose spray on her bedside table. Resident #14 said her family member brought it to her today. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/02/24 at 03:42 PM Resident #14 had a caddy sitting in her bathroom that had a container of vagisil maximum strength cream, preparation H hemorrhoidal ointment, and an asper creme lidocaine roll on container. During an observation on 12/03/24 at 08:51 AM Resident #14 continued to have the Vagisil maximum strength cream, preparation H hemorrhoidal ointment, and an asper creme lidocaine roll on container in her caddy in her bathroom. During an observation and interview on 12/04/24 at 10:23 AM CNA D walked in Resident #14's bathroom with surveyor and the vagisil maximum strength cream, preparation H hemorrhoidal ointment, and an asper creme lidocaine roll on container continued to be in Resident #14's caddy in her bathroom. CNA D said Resident #14 should not have the medications in her room, but resident was independent with her ADLs most of the time, so the CNAs do not always come into her bathroom. CNA D removed the medications from Resident #14's bathroom. CNA D said the failure placed Resident #14 at risk of self-medicating as well as wandering residents getting a hold of the medication. CNA D also found the bottle of fluticasone 50mcg allergy relief nose spray and 2 bottles of systane eye drops in Resident #14's dresser drawer. CNA D said all staff were responsible for ensuring no resident had medications in their rooms. During an interview on 12/04/24 at 04:56 PM the DON said her expectation was for all residents' medications to be locked in the proper location. She said they had sent letters out to the families to inform them of things that should not be brought into the facility and left with the residents. The DON said during rounds the staff should have found the medications being left out in Resident #14's room and bathroom. The DON said the failure placed Resident #14 at risk of self-treating and not fixing the problems she had. She said the failure could have also caused harm or injury for Resident #14 or any wandering residents that could get into the medications. During an interview on 12/04/24 at 05:04 PM The Administrator said she had sent out letters to the families of residents in the facility about hazardous items not to be left with residents, including medications. The Administrator said her expectation was for the medication to be stored in medication carts and medication rooms. She said all staff were responsible for ensuring that the medications were not in the residents' rooms. The Administrator said the failure placed staff at risk of not knowing what Resident #14 was taking and they could have possibly medicated her with medications that she could have had adverse reactions with. Record review of the facility policy Storage of Medications revised on 08-2024 indicated: Policy Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. I. General guidelines .2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 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 in 1 of 1 kitchen reviewed for dietary services, and in that: 1) The facility failed to date all food items. 2) Dietary staff failed to dispose of expired foods items 3)The facility failed to ensure proper infection control measures when a resident self-served ice from the ice chest cooler located on Hall 2 on [DATE], [DATE] and [DATE]. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During observation in the kitchen Refrigerator 1 of 3 on [DATE] at 9:56 a.m., the following was observed: -(1) gallon of 2 percent milk unopened expired on [DATE]. During observation in the kitchen Refrigerator 2 of 3 on [DATE] at 10:03 a.m., the following was observed: -(1) serving of hot sauce prep date of [DATE]. (expired) During observation in the kitchen on [DATE] at 10:17 a.m., the following were observed: -(1) 6-ounce container of pumpkin spice seasoning received on [DATE] had a use by date of [DATE]. -(1) 6-ounce container of ground ginger had an open date of [DATE] and a use by date of [DATE] -(1) container of frosted flakes had a prep date of [DATE] and no use by date. -(1) container of Raisin Bran Cereal had a prep date of [DATE] and no use by date. -(1) container of cheerios cereal had a prep date of [DATE] and no use by date. -(1) container of fruit loop cereal had a prep date of [DATE] and no use by date. During an interview and observation of the kitchen on [DATE] at 10:03 a.m., the Dietary Manager stated the hot sauce was good for a few months once prepped and the hot sauce should have been discarded from the refrigerator. The Dietary Manager stated the cereal should have had a use by date on the label. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:30 p.m., the dietary manager stated he had been the Dietary Manager for a year. The Dietary Manager stated the Administrator oversaw him. The Dietary Manager stated, Yes all food items in the kitchen were to be labeled, dated with receive date, open date and expiration date. The Dietary Manager stated the last in-service on expired foods was last completed a month ago. The Dietary Manager stated he conducted a walk thru in the kitchen daily. The Dietary Manager stated he was aware of the hot sauce and missing use by dates on the cereal. The Dietary Manager stated he was not aware of the expired milk found in the refrigerator. The Dietary Manager stated once food was prepared that the food item was good for a week or two. The Dietary Manager stated it was important to ensure staff were discarding expired foods so that the residents did not get sick. During an interview on [DATE] at 1:39 p.m., the Administrator stated she had been employed at the facility for [AGE] years. The Administrator stated she oversaw the Dietary Manager. The Administrator stated all food items in the kitchen were to be labeled, dated with receive date, open date, and expiration date. The Administrator stated she did not know when the last in-service on discarding expired food items was last completed. The Administrator stated walk throughs were conducted by her weekly in the kitchen. The Administrator stated she was not aware of the surveyor's findings in the kitchen prior to Survey. The Administrator stated it was important to ensure the dietary staff were discarding expired refrigerated foods so that the expired foods were not a hazard to the residents. Record Review of the Food Safety: Food storage policy revised on [DATE] indicated, all food purchased will be wholesome, manufactured, processed, and prepared in compliance with all State, Federal, and local laws and regulations. Food will be handled in a safe and sanitary method to prevent contamination and food-borne illness; (6) Food removed from its original packaging will be labeled with the following: a. Receive Date, b. Open Date c. Contents in the Package; (9) Opened package or leftover food is to be tightly wrapped or covered in airtight, clean. containers. It should be labeled, dated with the opened or use by date. Do not keep leftovers in the refrigerator for more than 7 days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of FDA Food code dated 2022 indicated, ,d+[DATE].11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents. (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. 3. During an observation on [DATE] at 10:32 AM, a resident was self-serving ice into two personal cups from the ice chest cooler located on Hall 2. During an observation on [DATE] at 10:45 AM, a resident was self-serving ice into two personal cups from the ice chest cooler located on Hall 2. During an observation on [DATE] at 10:42 AM, a resident was self-servicing ice into two personal cups from the ice chest cooler located on Hall 2. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:32 PM, RN C said the residents are given ice by the staff from the ice chest coolers located on Hall 2 and Hall 5. RN C said she had noticed residents self - serving ice from the ice chest coolers but had never thought of it as being cross-contamination until the surveyor interview. RN C said, they would not know if the resident had washed their hands so that could cause some infection control issues. During an interview on [DATE] at 04:35 PM, the ADON said she was not aware of any residents self-serving ice from the ice chest coolers. The ADON said the staff provided the ice and water to the residents every shift. The ADON said it was an infection control issue and could cause cross contamination for the residents to self-serve ice. The ADON said she was the infection control preventionist and responsible for ensuring the facility is following procedures to prevent the spread of infections. During an interview on [DATE] at 4:45 PM, the DON said she was not aware of residents getting their own ice for the coolers in the hallways. The DON said residents should not be allowed to self-serve ice from the hallway coolers because of the risk of cross contamination. During an interview [DATE] at 05:50 PM, the Administrator said she expected infection control policies to be followed by all the staff and all staff was responsible to ensure cross contamination was not occurring in the facility. The Administrator said the staff were responsible to ensure fresh ice was served to the residents. The Administrator said to decrease the chance of cross contamination residents should not self-service ice from the hallway coolers. Record review of the facility's policy titled Infection Control dated [DATE], indicated, 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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Residents #17). 1.CNA A and CNA B failed to use enhanced barrier precautions by donning a gown when performing foley care on Resident #17 on 12/03/2024. 2.CNA A and CNA B failed to change their gloves after performing foley care on Resident #17 and touched the resident and clean surfaces on 12/03/2024. These failures could place residents at risk of exposure to communicable diseases, cross-contamination and infections. Findings included: Record review of the face sheet, dated 12/04/2024, revealed Resident #17 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Parkinson disease (a disorder of the central nervous system that affects movements, often including tremors), type 2 diabetes (a long term condition where the body had trouble controlling blood sugar and using it for energy), hyperlipidemia (a condition where there are high levels of fat particles in the blood), and obstructive and reflux uropathy (a condition where urine flow is blocked with the urinary tract causing urine to back flow upward into the kidneys). Record review of the comprehensive MDS assessment, dated 10/28/2024, revealed Resident #17 had clear speech and was sometimes understood by staff. The MDS revealed Resident #17 was usually able to understand others. The MDS revealed Resident #17 had a BIMS score of 0, which indicated severe cognitive impairment. The MDS revealed Resident #17 was dependent on staff assistance for toilet hygiene and transfers. The MDS revealed Resident #17 had a foley catheter. Record review of Resident #17's orders summary dated 10/10/2024 indicated cleanse foley catheter insertion site with Thera Worx (hygiene protective barrier) to prevent urinary tract infections and provide foley care every shift. Record review of the comprehensive care plan, revised on 12/02/2024, revealed Resident #17 was on enhanced barrier precautions for indwelling catheter with the intervention of staff will gown and glove during high contact resident care. Record review of Resident #17's comprehensive care plan, revised on 10/10/2024, revealed resident had indwelling catheter and at risk for increased urinary tract infections with the intervention of monitor for signs and symptoms of infection. There was a sign posted regarding use of enhanced barrier protection and personal protection equipment was located in Resident #17's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/03/2024 at 4:09 PM, CNA A and CNA B entered Resident #17's room and donned gloves after washing their hands. CNA A and CNA B did not wear a gown for enhanced barrier protection. CNA B performed foley care for Resident #17. CNA A assisted CNA B. CNA A placed the foley catheter bag and tubing on the bed next to Resident #17's leg. CNA A unclamped the tubing from the leg stabilization device and held the tubing while CNA B performed foley care and placed the foley catheter bag below the bladder. CNA A and CNA B did not change their gloves. CNA A and CNA B touched Resident #17's clean brief, blanket and bed side table with the same gloves. After covering Resident #17 and adjusting the bed side table, CNA A and CNA B took off their gloves and washed her hands. During an interview on 12/04/2024 at 01:38 PM, CNA A said she should have used enhanced barrier precautions because Resident #17 had a foley. CNA A said she forgot to grab a gown when providing foley care for Resident #17 to prevent cross contaminations. CNA A said it was important to take dirty gloves off before touching anything clean to prevent spreading germs. She said staff had to take off their dirty gloves, wash their hands and re-glove, if needed. She said it was an infection control issue to touch items or residents with dirty gloves. She said she was trained and educated on enhanced barrier precautions and to remove her dirty gloves before touching anything clean and washing her hands to prevent infection. During an interview on 12/04/2024 at 04:22 PM, CNA B said she should have changed her gloves after the foley care when her gloves were dirty and before touching the resident's brief, blanket and bed side table. She said she was trained to change her gloves and clean her hands after foley care, and she did not because she was nervous. She said what she did was an infection control issue and could spread infection. CNA B said she failed to use enhanced barrier precautions by not utilizing a gown during foley care. CNA B said she is a new CNA and worked at the facility a short time (hire date of 11/21/2024). CNA B said she was assigned to work with a seasoned nurse until orientation completed. CNA B said she was not familiar with the residents on hall 2 and was nervous and realized afterwards the procedure was not done correctly. CNA B said she was aware and had been educated on all residents with foley care required enhanced barrier precautions to prevent the spread of germs and infections. During an interview on 12/04/2024 at 04:35 PM, the ADON said she was the Infection Preventionist. The ADON said it was her job to train, educate and complete skills check evaluations on the CNAs for foley care and enhanced barrier precautions to prevent the spread of infections in the facility. The ADON said it is her responsibility to monitor the staff through random checks, observations, and education to ensure infection control practices are being followed by staff. The ADON said she had started the position about 2 months ago and she had not completed any skill evaluations yet for any staff. The ADON said she was learning her position and would resume the evaluations in January 2025. The ADON said touching clean surfaces with dirty gloves could cause cross contamination of the clean area especially if someone else touched the dirty area with clean gloves or hands. She said the danger to the resident was infection, weight loss and an infection could require the resident to be on antibiotics. The ADON said enhanced barrier precautions should be used for all residents with a foley. The ADON said there were signs in the Resident's rooms to alert staff and the necessary supplies required for enhanced barrier protection such as gowns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455944	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Clarksville	2407 West Main Street Clarksville, TX 75426

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/2024 at 4:45 PM, the DON said she expected the staff to follow the procedures for foley care which included enhanced barrier precautions which required wearing the gown during foley care. The DON said infection control was vital for all staff to adhere to and prevent cross contamination. The DON said staff should never touch the residents or resident's items such as linens or reposition the residents with dirty gloves. She said to do that was cross-contamination which could spread infection or cause infection. She said she expected staff to go by their training and change their gloves after a dirty procedure and perform hand hygiene. She said dirty gloves should be changed and hand hygiene performed before going to a clean area. The DON stated she had performed skill evaluations for the staff while the ADON was training. The DON said CNA B was hired approximately three weeks ago and had not completed skills evaluation at this time. During an interview 12/04/2024 at 05:50 PM, the Administrator said she expected staff to follow best practices learned when obtaining their licensure. The Administrator said enhanced barrier precautions were important to protect the residents as well as the staff from infections and should be utilized with residents that had a foley. She said if a staff had dirty gloves on and touched a clean area it was cross-contamination and could possibly cause infection. The Administrator said she felt that CNA A and CNA B were nervous when the surveyor observed the care provided. Record review of a skills check off entitled CNA Skills Fair 2024 - Incontinent Care - Peri/Incontinent Care with Catheter - Male, dated 10/25/2024, indicated CNA A was competent in foley care. Record review of a skills check off entitled CNA Skills Fair 2024 indicated CNA B had not completed the skills check for foley care. Record review of the facility policy titled Enhanced Barrier Precautions, dated 04/01/2024, indicated: Enhanced Barrier Precautions are a CDC guidance to reduce the transmission of multi-drug resistant organisms in health care setting, including nursing homes .requires team members to wear a gown and gloves while performing high contact care who have open wounds or indwelling catheters. Record review of the facility's policy titled Catheters-Insertion and Care, dated 04/2021, indicated: It is the policy of this community that the resident with a urinary catheter will be provided services in a safe and appropriate manner to minimize the risks of urinary tract complications 3. wash hand, put on gloves 17. remove gloves and wash hands. 18. Leave resident in a comfortable position with call light within reach.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 1 of 19 residents (Resident #14) reviewed for physical environment. The facility failed to ensure Resident #14's bathroom toilet was functioning properly. The facility failed to ensure Resident #14's bathroom toilet was not briskly running or leaking water for her to use safely. This failure could place residents at-risk of falls and further injuries due to an unsafe environment. The findings were: Record review of Resident #14's face sheet dated 12/04/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses high blood pressure, arthritis, seasonal allergies, and abnormal posture. Record review of Resident #14's admission MDS assessment dated [DATE] indicated she was able to make herself understood and able to understand others. The MDS also indicated she had a BIMS score of 14 which meant she was cognitively intact. The MDS also indicated Resident #14 was always continent of bowel and bladder. Record review of Resident #14's care plan dated 09/26/24 indicated her discharge had been determined to not be feasible based on resident and family request and need for ADL assistance and assistance with medication administration. The care plan also indicated Resident had impaired visual functioning and was at risk for a decrease in ADLs and injuries and she wears glasses. Record review of the facility maintenance request book on 12/02/24 at 03:58 PM indicated there were no maintenance requests noted in the book for Resident #14 for September 2024, October 2024, nor November 2024. During an observation and interview on 12/02/24 at 03:42 PM Resident #14 was sitting in her room and she said she forgot to tell the surveyor about her toilet running and leaking since she admitted to the facility on [DATE]. Resident #14 said her toilet had been having problems since she admitted on [DATE] and she had told staff. The toilet in her room was briskly running water but there was no observation of water on the floor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/02/24 at 04:03 PM the Maintenance Director said he was aware of the problem with Resident #14's toilet about 3 weeks prior to 12/02/24. The Maintenance Director said he did not have the problem in his maintenance book because he found the problem with Resident #14's toilet running water while he was making rounds to check water temperatures. The Maintenance Director said Resident #14's toilet flapper was not functioning, and he fixed it by replacing it at that time. The Maintenance Director said he would have normally documented in his book, but he did not on that occasion. He said he was not aware the toilet was not operating properly. During an observation on 12/04/24 at 10:35 AM Resident #14's toilet water was leaking on the floor from her toilet to her room. She had left the room, but someone had attempted to use paper towels to try to dry the water up and left paper towels on the floor in the leaking water. During an interview on 12/04/24 at 10:39 AM Community Cleanliness Provider E said he had never noticed the toilet leaking or running but he was not always scheduled to work on Resident #14's hallway. During an observation and interview on 12/04/24 at 10:44 AM Maintenance Director said he came back down to the room on the afternoon of 12/2/24 and checked Resident #14's toilet after he rebuilt (he removed the toilet and put it back together) the toilet and there were no problems with it running or leaking. He said he was responsible for ensuring the toilets in the facility were functioning properly, but he did not know it was leaking. The Maintenance Director said the leaking toilet placed Resident #14 at risk for slipping and falling. During an interview on 12/04/24 at 04:53 PM the DON said her expectation was for the toilet in Resident #14's room to be functional and not leaking. She said the Maintenance Director was responsible for ensuring that the toilet was fixed but all staff were responsible for ensuring all residents' toilets were functioning and reporting in the maintenance book when the toilets were not functioning. The DON said the failure placed Resident #14 at risk for falls. During an interview on 12/04/24 at 05:02 PM the Administrator said her expectation was for the residents' toilets functioning and running properly but she felt the leaking toilet was a different problem that was newly found. The Administrator said the Maintenance Director was responsible for all the maintenance and toilets in the facility. She said the failure placed Resident #14 at risk of injury. Record review of the facility policy Quality of Life-Homelike Environment revised May 2017 indicated: Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment .