

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n Gilmer, TX 75644	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295</p> <p>Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 9 residents (Resident #'s 1 and #2) reviewed for abuse.</p> <p>The facility failed to ensure CNA G did not verbally and physically abuse Resident #1 during incontinent care.</p> <p>The facility failed to ensure CNA G did not verbally and physically abuse Resident #2 during incontinent care.</p> <p>This failure could place residents at risk of abuse, humiliation, intimidation, fear, mental distress, depression, and decreased quality of life.</p> <p>Findings included:</p> <p>1. Record review of the undated face sheet revealed Resident #1, a [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet revealed she had diagnoses that included: Nondisplaced fracture of coracoid process, left shoulder (broken shoulder), Paroxysmal atrial fibrillation (irregular and rapid heart rhythm), hypertension (pressure in blood vessels is too high), heart failure (heart does not pump blood as it should), muscle weakness, anxiety (feeling of fear, dread uneasiness), depression (low mood, loss of pleasure), and cancer of the rectum and bilateral lungs.</p> <p>Record review of the quarterly MDS dated [DATE] revealed Resident #1 had minimal difficulty hearing and clear speech, usually understood others, and was understood by others. Resident #1 had a BIMS score of 12 indicating moderate cognitive impairment. She had impairment on one side of her upper extremity and both lower extremities were impaired. Resident #1 required partial to moderate assistance for a chair/bed to chair transfer and supervision for bed mobility. She was frequently incontinent of urine and occasionally incontinent of bowel. Diagnoses on the MDS indicated she had fractures and other multiple trauma.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the undated care plan revealed Resident #1 had a history of a left shoulder fracture and needed assistance with ADL's. She was incontinent. Resident #1 had impaired cognitive function or impaired thought processes and was not always able to understand verbal and non-verbal expression, with difficulty making decisions.</p> <p>Record review of an Admit/Readmit Screener dated 2/25/24 indicated Resident #1 admitted [DATE] with a shoulder fracture and immobilizer (keeps the arm from moving up, down, or away from the body) to her right arm. She had bruising and skin tears from a ground level fall at home.</p> <p>Record review of the PIR dated 3/21/24 indicated Resident #1 told CNA H that CNA G hit her and threw her around all day. CNA H reported this to LVN F. LVN F assessed the resident and reported no injuries. LVN F asked Resident #1 what happened. It was reported that Resident #1 stated that she did not want CNA G back in her room because she was too rough and was throwing her around all day. She hurt my feelings. LVN F asked if she was physically hurt and Resident #1 said no. Administrator, DON, physician, and family notified. CNA G suspended pending investigation. SW performed safe surveys and assessed resident for needed follow up care or emotional distress. Interview with multiple staff members involved in her care during the day. Witnesses confirmed no physical 'hitting' happened during care. CNA G reportedly was pushing resident during rolling and spoke with resident in unpleasant tone regarding the care. 'What do you want me to do, I still need to wipe you.' The investigation findings were confirmed for abuse. Provider action taken post-investigation indicated in-service provided on abuse and neglect. Safe surveys did uncover another customer service care related complaint in regard to the care CNA G provided. Another resident reported she was rough and talked rudely, as well as has personal conversations with others in the room during care. CNA G was terminated and would not return.</p> <p>Record review of the PIR indicated the following interviews:</p> <p>Interviews conducted by prior ADM:</p> <p>*Phone interview with LVN F on 3/21/24 at 7:30 PM - Reported that CNA H stated that Resident #1 reported that CNA G was too rough and throwing her around all day. LVN F did a full assessment and no new injuries present. During her assessment Resident #1 was asked what happened and LVN F reported that she stated it was the day before and she did not want CNA G back in her room because she was rough and rude during incontinent care. She hurt my feelings. LVN F reported that she asked Resident #1 if she was physically hurt and she said No.</p> <p>*Interview with CNA H on 3/21/24 at 7:40 PM - CNA H reported that Resident #1 said CNA G hit her and threw her around. She said had not been changed all day and she was verbally assaulted by CNA G at lunch and her whole body hurt because of her.</p> <p>*Interview with Resident #1 on 3/22/24. Resident #1 reported that the incident with CNA G happened yesterday morning and CNA G was speaking with her rudely because she had another bowel movement. Resident #1 said CNA G said This is what you called me for, I don't think you should need this much help. The ADM asked if CNA G hurt her and Resident #1 stated that CNA G was too rough with her rolling her, threw me around like a rag doll. The prior ADM asked if CNA G had hit her and Resident #1 said No, she did not hit me. Resident #1 denied having any pain anywhere.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Interview with CNA B on 3/22/24 - HA B reported she was present during care. HA B stated that Resident #1 was crying out with rolling and wiping, due to pain in her shoulder and burning on her bottom. CNA G stated I still need to wipe you. HA B said that was all CNA G said.</p> <p>*Interview with CNA C on 3/22/24 - stated she was present during care for Resident #1 and Resident #1 cried out when she was rolled on to her painful shoulder, and was crying while CNA G was wiping her. CNA C said CNA G stated I'm sorry, what do you want me to do about it.</p> <p>*Interview with CNA J on 3/22/24 - CNA J stated that she entered the room right after care, and Resident #1 did not report any physical abuse, just that she said she felt CNA G was rude and did not want her back in her room.</p> <p>*Interview with RN E on 3/22/24 - RN E reported she was in the room after CNA G had finished care and Resident #1 reported that she did not want CNA G back in her room. RN E asked her shy and she stated because CNA G stated Don't tell me how to do my job. When she went to leave. Resident #1 did not report any other reason or discuss any allegation of abuse or rough care.</p> <p>Safe survey's conducted on 3/22/24 indicated Resident #2 reported CNA G was rude and rough during care.</p> <p>In-services done on Abuse and Neglect on 3/22/24.</p> <p>2.Record review of the undated face sheet revealed Resident #2, a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: mild dementia (impairment in memory and judgement), morbid obesity (a complex chronic disease in which a person has a body mass index of 40 or higher), congestive heart failure (the heart does not pump enough blood to the body), heart disease (a disease affecting the heart and blood vessels), and low back pain.</p> <p>Record review of the quarterly MDS dated [DATE] revealed Resident #2 had minimal difficulty hearing and clear speech, usually understood others, and was usually understood by others. Resident #2 had a BIMS score of 13 indicating intact cognition. She had impairment on one side of her lower extremities and required supervision or touching assistance for bed mobility and was totally dependent for a chair/bed to chair transfer. She was always incontinent of bowel and bladder.</p> <p>Record review of the undated care plan revealed Resident #2 required assistance with ADL's with assistance by staff for toileting and to move between surfaces. She was incontinent. She was non-weight bearing with generalized weakness.</p> <p>During an interview on 7/8/24 at 10:13 AM, CNA A said she had worked at the facility about 2 years. She said CNA G was a rude person, she said not abusive, but talked loud. She said CNA G was very matter of fact and spoke the same way to the nurses. She said Resident #1 told her CNA G was rude. She said CNA G did a good job with the residents. She said some residents did like her and some did not.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/8/24 at 11:11 AM, Resident #2 said she did not care for CNA G. She said she was great when she started but she began getting rough. She said one time when she was changing her, another HA B was in the room and CNA G was getting rough and she asked her not to be rough. She said CNA G said she was not being rough and Resident #2 said Don't touch me. She said CNA G stopped care and HA B finished her care. She said CNA G was fired. She said she was glad she was fired. She said she did not have any lingering effects from the ordeal but was aggravated at the time.</p> <p>During a phone interview on 7/8/24 at 4:28 PM, HA B said she assisted CNA G to turn Resident #1. She said Resident #1 was always kind of angry and she had surgery. She said Resident #1 yelled when she and CNA G turned her. She said she explained to Resident #1 that they had to turn her to change her. She said CNA G was already in a foul mood and she knew CNA G and Resident #1 had some words. She said she did not remember what the words were but there was no cursing or anything, just rude/angry words between them. She said CNA G was already upset over an incident with Resident #2. She said CNA G was in Resident #2's room and came out of the room crying, saying something to the effect of -why are all the residents against me. HA B said she finished the care for Resident #2. She said Resident #2 told her that CNA G was rough with her when she was caring for her. She said she believed Resident #2. She said she had not ever seen CNA G be rough with a resident but Resident #2 told her about it. HA B said she believed CNA G was abusive to Resident #1 and Resident #2.</p> <p>During a phone interview on 7/8/24 at 4:53 PM, CNA C said she and CNA G went into Resident #2s room to change her and Resident #2 told CNA G to stop talking about outside stuff while she was in her room. She said CNA G was irritated when Resident #2 said that. She said CNA G was taking Resident #2's gown off and did it roughly. She said the gown was partially untied but not completely untied. She said she did not know if she was trying to be rough or trying to get the gown off. CNA C said CNA G told Resident #2 she would talk about whatever she wanted to. Resident #2 said Not while you are changing me. CNA C said CNA G left the room and she finished changing her then reported the abuse to the nurse LVN D.</p> <p>During a phone interview on 7/8/24 at 5:50 PM, LVN D said she did not remember CNA C reporting abuse to her. She said there were 3 nurses with the same first name at the facility though.</p> <p>During an observation and interview on 7/9/24 at 8:24 AM, Resident #1 was in her room in her wheelchair with glasses on. She said she had forgotten about the incident with CNA G. This surveyor had to read her part of the PIR, then she remembered. She said she had forgotten. She said she had just had shoulder surgery and CNA G was changing her and she was rough. She said it hurt her shoulder and she told her it hurt. She said CNA G did not apologize. She said she did not know if she was being mean or rough but she did not like her. She said she reported it to someone in the front and did not see CNA G again. She said it did not bother her because she had forgotten about it. She said everything was good now.</p> <p>During an attempted phone interview on 7/9/24 at 9:12 AM, CNA G's phone number was no longer working.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/9/24 at 9:23 AM, the ADON said at the time CNA G was changing Resident #1 she was right across the hall in her office. She said Resident #1 said she yelled and she never heard her yell. She said Resident #1 could be very loud and was very vocal. She said she did not believe it happened the way Resident #1 said it did. She said she believed it was a race/color thing. She said Resident #1 had said black slang names. She said from what she saw CNA G was kind and good with residents. She said she was a great aide. She said no other residents complained about CNA G, other than she talked about personal things. She said Resident #2 said CNA G and HA B talked too much about their personal lives in front of her.</p> <p>During an interview on 7/9/24 at 9:56 AM, RN E said she did not feel like CNA G intentionally aggressive, but when Resident #1 first got to the facility she was super confused. But, she cannot speak to what goes on behind closed doors. She said she thought there was another CNA in the room at the time and she thought that CNA said she was not aggressive, but she did not know what really happened. She said she was not aware of CNA G being abusive with Resident #2.</p> <p>During an attempted phone interview on 7/9/24 at 3:18 PM, called LVN F. She did not answer, left a message for her to return surveyor's call.</p> <p>During an attempted phone interview on 7/10/24 at 8:06 AM, called LVN F. She did not answer, left a message for her to return surveyor's call.</p> <p>During an interview on 7/10/24 at 9:15 AM, the DON said she believed CNA G was abusive to Resident #1 and Resident #2 probably physically and for sure verbally. She said CNA G was trained in abuse and neglect. She said CNA G only worked at the facility about a week, so she really did not know her well. She said you never know who would do that. The DON said she did not know how they could have prevented the abuse because CNA G was trained and she passed all the background checks. She said Resident #1 and Resident #2 did not have long lasting effects from CNA G. She said both Resident #1 and Resident #2 told her they were not afraid and were okay right after it happened and she checked on them a few days after it happened and they said they were fine.</p> <p>During an interview on 7/10/24 at 10:15 AM, The ADM said she had been at the facility for 3 weeks with a starting date of 6/17/24. She said she did not work at the facility in March of 2024 but said she believed she would have come to the same conclusion that the facility did at the time, confirmed abuse. The ADM said she believed CNA G had physically and verbally abused Resident #1 and Resident #2. She said the facility did everything they could have done to prevent the abuse, gave CNA G education on abuse, did the background checks, and taught her how to treat a resident. Then, then when she did not meet those expectations, they suspended then terminated her. She said CNA G was only here a week. She said Resident #1 and Resident #2 did not have any lasting effects from the abuse. She said she had visited with them numerous times and they never brought it up. She said she did not ask about it.</p> <p>Record review of CNA G's time sheet indicated she worked at the facility 3/14/24, 3/15/24, 3/16/24, 3/17/24, 3/20/24, and 3/21/24.</p> <p>Record review of CNA G's personnel file indicated she was hired 3/14/24 with criminal history and employee misconduct registry run on 3/13/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the training for CNA G indicated on 3/14/24 she was trained on the facility Abuse Policy, and Statement of Resident Rights and also signed the Senate [NAME] 9 Acknowledgement.</p> <p>Record review of an Abuse Policy dated 2/1/17, revised 7/10/18 indicated .The purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect, Intimidation Involuntary Seclusion/Confinement, and or Misappropriation of property. The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policy and procedure. The facility administrator is the appointed Abuse Coordinator, and in his/her absence a designee will be appointed. Abuse is willful infliction of injury or negligent, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident o r sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under penal code S 21.08 (indecent exposure) or Penal code chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault. Residents will not be subjected to abuse by anyone, including, but not limited to community staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, care taker, friends, or other individuals .</p>		