STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675602	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Gilmer	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 residents reviewed for infection control practices (Resident # 7). 1.The facility failed to ensure CNA A and CNA B wore personal protective equipment while providing incontinent care for Resident #7 who was on EBP with a Foley catheter (a thin, flexible tube inserted through the urethra into the blader to facilitate urine drainage), Gastrostomy tube (is a feeding tube that delivers nutrition to your stomach) and a wound on 11/1/2025. 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 11/7/2025 indicated Resident #7 was a [AGE] year old male who was re-admitted on [DATE] with diagnoses which included end stage renal disease (a gradual loss of kidney function), osteomyelitis (an infection in a bone that can affect one or more parts of the body into the bone), acute on chronic systolic heart failure (a condition in which the left ventricle of heart is weak), neuromuscular dysfunction of bladder (occurs when nerve damage impairs bladder control), gastrostomy (a medical procedure that involves creating an artificial opening through the skin into the stomach), atherosclerotic heart disease of native coronary artery without angina pectoris (a progressive disease where plaque, composed of fat, cholesterol, calcium and other substances, accumulates in the walls of the arteries), peripheral vascular disease (refers to any disorder that affects the blood vessels outside of the heart and brain), acquired absence of right below the knee (refers to the loss of the lower portion of the right leg) and depression (a mood disorder that causes persistent feeling of sadness and loss of interest). Record review of the physician's orders dated 11/7/2025 indicated Resident #7 was on enhanced barrier precautions related to Foley catheter, Gastrostomy tube and wound care. Record review of Resident #7's MDS assessment, dated 8/28/2025, indicated the resident was sometimes understood and sometimes understood others. The MDS also indicated Resident #7 was unable to complete BIMS. The MDS indicated Resident #7 required substantial, maximum assistance with showering/bathing, and dressing lower body. He was dependent on toileting and putting on/taking off footwear and was dependent on mobility. Record review of the undated care plan indicated Resident #7 was on enhanced barrier precautions due to foley catheter, gastrostomy status and chronic wounds. Interventions included educating the resident and the family on the reason and procedure of EBP, ensure signage is posted, ensure PPE is available for use on the resident and notify the physician of any signs and symptoms of infection. During review of photo evidence submitted by RP on 11/7/2025 at 12:56 PM, a photo dated 11/1/2025 at 10:13 AM from video recorder in Resident #7's room revealed 2 staff members providing incontinent care to Resident #7 without proper PPE on. Record review of daily staffing dated 11/1/2025 indicated CNA A and CNA B were scheduled to work 6 AM to 2 PM. Record review of a certification titled Enhanced Barrier Precautions dated 8/26/2025 indicated CNA A completed her training. Record review of a certificate titled Enhanced Barrier Precautions dated 8/4/2025 indicated CNA B completed her training. During a phone interview on 11/8/2025 at 9:36 AM, CNA A said she assisted on the floor and had come to the facility for a few hours. She said she was at the facility from approximately 9 am- 12:30 pm. CNA A said she recalled she assisted CNA B with changing Resident #7. She said she could not recall if she wore PPE while providing incontinent care to Resident #7. CNA A said she has not always worn PPE while providing care. She said she believed she wore PPE on 11/1/2025. CNA A said a resident on EBP precautions would have a plan of care in the computer and the supplies would be in the room with an orange sticker on the door. CNA A said if proper PPE were not worn, it could cause infection if my clothes were contaminated. She said it would be an infection control issue. CNA A said the facility had plenty of PPE. CNA A said the nurses, charge nurses, ADON and DON were responsible for ensuring the staff was wearing proper PPE and the aides were following proper precautions. CNA A said she had been in-serviced on PPE and EBP through townhalls and through the facility's online in-services. During a phone interview on 11/8/2025 at 9:47 AM, CNA B said she worked at the facility PRN, and she did not think she worked that day. CNA B said she did recall providing care to Resident #7. CNA B said she was not familiar with EBP. She said she wore a gown if a resident had an open wound. She said you never wear gowns while performing incontinent care with residents with a catheter and she said she was not required to wear a gown with a resident with a feeding tube. CNA B said she felt the facility had plenty of PPE. She said