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	11/25/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 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 provide a safe, clean, and comfortable homelike environment for 1 of 11 residents (Resident #3) reviewed for the physical environment. The facility failed to ensure Resident #3's room was clean and free of strong urine odors. This failure could place residents at risk for a decreased quality of life and an unsanitary environment. The findings included: Record review of the face sheet, dated 11/25/25, reflected Resident #3 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of hypertensive heart disease with heart failure (long-term condition caused by high-blood pressure, which resulted in heart failure), paraplegia (weakness or paralysis of the lower legs), and spinal stenosis (narrowing of the spinal canal). Record review of the quarterly MDS assessment, dated 9/18/25, reflected Resident #3 had clear speech, was understood by others, and was usually able to understand others. Resident #3 had a BIMS score of 13, which indicated no cognitive impairment. The MDS reflected no behaviors or refusal of care. Resident #3 usually required total assistance from staff with toileting hygiene and was occasionally incontinent of urine. Record review of the comprehensive care plan, undated, reflected Resident #3 preferred no staff to enter his room through the night. The interventions included: will use the urinal for toileting and nurse will check him at the beginning and the end of the shift for any needs. Record review of the comprehensive care plan, undated, reflected Resident #3 needed assistance with ADLs. The interventions included: Toilet Use: The resident requires assistance by staff for toileting. Record review of the comprehensive care plan, undated, reflected Resident #3 was occasionally incontinent of urine and required assistance with toilet hygiene. The interventions included: monitor for incontinence every 2 hours and as needed, change promptly, and apply protective skin barrier. During an interview and observation on 11/25/25 beginning at 9:19 AM, Resident #3 was lying in his bed with the head of the bed elevated. He was playing on his laptop computer. There was a strong urine odor in the room. Resident #3 had two urinals that were hanging on the trashcan located beside his bed. There was a small amount of yellow urine noted in both urinals. The floor beside the trashcan and bed appeared wet in some areas but was drying around the outside of some of the puddles that gave the floor a matte appearance. The floor was sticky and there were two flies flying around the floor. Resident #3 stated he constantly had trouble with staff wanting to empty his urinals. Resident #3 stated he did not mind if staff came in at night to empty his urinals, but he did not like to be woken up. Resident #3 stated that even during the day, the staff did not empty his urinal often enough to keep it empty. Resident #3 stated he did not like to wet his pants, so sometimes he emptied the urinal in the trashcan so he could use it. Resident #3 stated he wished the staff would have emptied his urinal sooner, and he felt that it made his room smell like urine. During an interview on 11/25/25 at 11:14 AM, CNA C stated she normally worked as needed on Hall 1 or Hall 2. CNA C said urinals should have been emptied at least every 2 hours when rounds were completed. She said Resident #3 asked her to empty his urinal around 6 AM, when she arrived on shift. CNA C stated the urinal was overflowing onto the ground beside his bed. She stated she tried to clean the urine up as best as she could. She stated Resident #3's room always smelt like urine because he used the urinal and was occasionally incontinent of urine. CNA C stated it was important to ensure strong urine odors were addressed by the facility staff. She stated she usually notified the housekeeping staff and then wiped his bed down with purple top wipes. She stated it was important to maintain a clean and homelike environment. During an interview on 11/25/25 at 11:27 AM, Housekeeper D stated she had worked at the facility for a couple of months. Housekeeper D stated she had problems with Resident #3's room smelling like urine. Housekeeper D stated Resident #3 used the urinal and could not physically get up to use the bathroom. She said Resident #3 was dependent on staff and when his urinal was full, he would empty it into the trashcan. Housekeeper D stated that sometimes Resident #3 missed the trashcan and the urine got on the ground. Housekeeper D stated the housekeeping staff cleaned his room daily, to include sweeping and mopping. She stated they did not have any special cleaners for urine odors. She stated it was important to ensure odors in the resident's rooms were pleasant for a more homelike environment. She stated family and visitors did not want to step on sticky floors or smell urine odors. During an observation on 11/25/25 at 1:09 PM, Resident #3 was sitting up in bed eating his lunch meal. There was a strong urine odor in the room. Resident #3 had two urinals that were hanging on the trashcan located beside his bed. There was a small amount of yellow urine noted in both urinals. The floor was sticky and there were four flies flying around the floor.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 2 residents (Resident #1 and Resident #2) reviewed for incontinent care. 1.The facility failed to ensure CNA A changed gloves and performed proper hand hygiene before going from dirty to clean during Resident #1's catheter and incontinent care on 11/25/25. 2. The facility failed to ensure CNA B performed hand hygiene before applying new gloves and changed gloves before going from dirty to clean during Resident #2's incontinent care on 11/25/25. These deficient practices could place residents at risk for decreased quality of life, infection, and skin breakdown due to improper care practices. The findings included: 1.Record review of Resident #1's face sheet, indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included frontotemporal neurocognitive disorder (dementia involving the progressive degeneration of the brain's frontal and temporal lobes), down syndrome (a genetic condition caused by an extra copy of chromosome 21, resulting in intellectual disability), paraplegia (a condition characterized by the loss of motor and sensory function in the lower half of the body), neuromuscular dysfunction of bladder (a condition where nerve damage disrupts the communication between the brain and bladder leading to issues with controlling urination), need for assistance with personal hygiene and osteomyelitis (a bone infection caused by bacteria or fungi that can enter the bone through the bloodstream, an open wound, or recent surgery). Record review of Resident 1's quarterly MDS assessment, dated 11/12/25, indicated Resident #1 was sometimes understood by others and usually understood others. The MDS assessment indicated he had a BIMS score of 10 indicating moderate cognitive impairment. The MDS did not indicate Resident #1 refused care. The MDS indicated she was always incontinent of bowel and bladder. Record review of Resident #1's comprehensive care plan, dated 8/07/25, indicated Resident #1 was incontinent of bowel and had a foley catheter. Resident #1 was at risk for skin breakdown. The interventions were to monitor for incontinence every 2 hours/ PRN, change promptly and apply protective skin barrier and assess for causes of incontinence. Record review of Resident #1's comprehensive care plan, dated 8/07/25, indicated Resident #1 had a self-care deficit: Resident #1 needed assistance with ADL's related to down syndrome (a genetic condition caused by an extra copy of chromosome 21, resulting in intellectual disability). The interventions for personal hygiene were; the resident requires assistance by staff with personal hygiene and oral care. Record review of Resident #1's order summary report dated 08/07/25 indicated D-Mannose oral capsule (D-Mannose), Give 1300 mg by mouth one time a day for frequent UTI. Record review of Resident #1's order summary report dated 10/07/25 reflected Gentamicin 80 mg/50 mL normal saline Injectable - Give 30mL intravesical (into the bladder) two times a day for frequent UTI. Hold in bladder 30 minutes by clamping foley catheter then let drain. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/25/25 at 9:10 AM, CNA A provided catheter and incontinent care to Resident #1. CNA A placed a trash bag for dirty items and wipes on Resident #1's bedside table. He did not clean the bedside table or place a barrier on the bedside table before placing items. CNA A removed Resident #1's covers and stuffed animals and placed catheter bag to the bottom of the resident's bed. CNA A explained what he was going to do to Resident #1. He wiped Resident #1's genital area starting with the outer folds of the pubis using a downward motion, then he cleaned labia minora. Lastly, he cleaned Resident #1's catheter. He then turned Resident #1 on her side while touching her buttocks and hips with the same dirty gloves on. He proceeded to wipe his buttocks using the front-to-back motion. After he performed incontinent care to Resident #1's backside he removed her dirty draw sheet and dirty brief then placed the items in bag on bedside table. CNA A applied Resident #1 with a clean brief and clean draw sheet. He repositioned Resident #1 in bed, replaced her covers over her, replaced her stuffed animals close to her head, replaced foley catheter bag to frame of bed and adjusted bed in lowest position with hand handle controller. CNA A gathered his trash and removed his dirty gloves. CNA A performed hand hygiene, by washing hands in the bathroom, for the first time since the catheter and incontinent care started and left the room. During an interview on 11/25/25 at 9:22 AM, CNA A said he should have changed his gloves before he started cleaning the resident's genital area, because he had touched her covers and foley catheter bag. He said he felt like he should have changed his gloves after cleaning the front side of the resident. CNA A said all the germs from the front side could have been transferred to the backside of the resident because he did not change his gloves. He said he should have changed his gloves and performed hand hygiene after he removed Resident #1's dirty brief and dirty draw sheet. He said he should have changed his gloves and performed hand hygiene prior to applying Resident#1's clean brief and clean draw sheet. CNA A agreed he did not have the appropriate barrier and did not sanitize Resident #1's bedside table prior to starting the care. CNA A said he should have changed his gloves and performed hand hygiene prior to replacing Resident #1's covers over her and replacing her foley catheter to bedrail. CNA A said he was sorry he did not change his gloves while providing care to Resident #1. He said he had been trained at the facility on incontinent care or handwashing. He said the negative effect of improper foley catheter and incontinent care, and improper hand hygiene was an infection issue. 2. Record review of the face sheet, dated 11/25/25, reflected Resident #2 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of multiple sclerosis (chronic autoimmune disorder that affects the central nervous system, including the brain, spinal cord, and optic nerves; the immune system attacks the protective covering of the nerve cells), urinary tract infection (bladder infection), and sepsis (blood infection). Record review of the quarterly MDS assessment, dated 11/17/25, reflected Resident #2 had clear speech, was understood by others, and was able to understand others. Resident #2 had a BIMS score of 15, which indicated no cognitive impairment. Resident #2 had no behaviors or refusal of care. The MDS reflected Resident #2 normally required substantial/maximum staff assistance with toileting hygiene. Resident #2 had an indwelling catheter and was always incontinent of bowel. Resident #2 had an active diagnosis of neurogenic bladder (bladder dysfunction caused by nerve damage) and urinary tract infection within the last 30 days. The MDS reflected Resident #2 took antibiotics within the look-back period. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the comprehensive care plan, undated, reflected Resident #2 had an indwelling catheter and was at increased risk for urinary tract infections. Resident #2 took an antibiotic prophylactically for frequent UTIs. Record review of the comprehensive care plan, undated, reflected Resident #2 had an ADL self-care performance deficit. The interventions included: extensive staff assistance with toilet use. Record review of the comprehensive care plan, undated, reflected Resident #2 had bowel incontinence related to Multiple Sclerosis. The interventions included: provide peri care after each incontinent episode. Record review of the comprehensive care plan, undated, reflected Resident #2 had an actual UTI. Record review of Resident #2's order summary report, reflected the following orders: 1. On 11/13/25, Admit to skilled services for diagnosis of UTI. 2. On 09/06/24, Enhanced barrier precautions during high contact and direct care activities every shift for catheter. 3. On 09/12/24, cranberry tablet 300 mg – give 1 tablet by mouth two times a day for prevention of UTIs. 4. On 5/20/25, D-mannose oral capsule 500 mg – give 2 capsules by mouth one time a day for recurrent UTI's. 5. On 05/20/25, Macrodantin (antibiotic) oral capsule 50 mg – give 1 capsule by mouth at bedtime for recurrent UTI's. During an observation and interview on 11/24/25 at 9:41 AM, Resident #2 was lying in the bed with the head of her bed slightly elevated. Resident #2 she had a Foley catheter since being admitted to the facility. She stated she was constantly getting UTIs and recently had a suprapubic catheter placed. Resident #2 had a catheter drainage bag hanging on the side of the bed with a small amount of clear yellow urine. There was no privacy cover, but Resident #2 stated it did not bother her. She stated she blamed her UTIs on the facility staff because they were not competent at following infection control practices during incontinent or catheter care. She said that she had to sit for 3 hours in her poop, and she had to use numerous wash rags in the shower to get herself clean. Resident #2 stated she was a germaphobe and it drove her crazy. During an observation on 11/25/25 at 10:28 AM, CNA B gathered her supplies for incontinent care on Resident #2. CNA B applied an isolation gown, washed her hands, then applied gloves. She performed incontinent care on Resident #2's front side, changed her gloves but did not perform hand hygiene. CNA B performed incontinent care on Resident #2's back side, then changed her gloves but did not perform hand hygiene. CNA B then wiped Resident #2 several more times, then took the clean linens and placed them under Resident #2 without changing her gloves. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/25 at 10:39 AM, CNA B stated she had no sanitizer in her pocket like she normally had, but she should have applied hand sanitizer each time she replaced her gloves. She said that she became busy when she started work and forgot to get a pocket sanitizer from the nurse's station. CNA B stated she should have changed her gloves after cleaning a dirty area and before she touched the clean linen. She stated she was nervous with the state watching. She stated it was important to ensure infection control practices were followed during incontinent care to prevent the spread of infection and prevent urinary tract infections. During an interview on 11/25/25 at 2:03 PM, the Assistant Director of Clinical Operations stated she expected the CNAs to ensure infection control practices were at the forefront of their mind while performing incontinent or catheter care. She stated the nursing management provided in-service education and check offs for incontinent and catheter care all the time. The Assistant Director of Clinical Operations stated she understood the staff became nervous when state surveyors were watching, but she still expected them to follow the infection control practices during incontinent or catheter care. She stated it was important to ensure infection control practices were followed during incontinent or catheter care to prevent the risk of urinary tract infections. The clinical checkoffs for incontinent care were requested for CNA A and CNA B. During an interview on 11/25/25 at 2:26 PM, the Director of Clinical Operations stated she expected the staff to ensure they were sanitizing their hands and changing gloves at the appropriate times during incontinent or catheter care. She stated the staff completed checkoffs and online training and in-service education. She stated next month several of the facilities were providing a skills fair that would have included incontinent care. The Director of Clinical Operations stated it was important to ensure infection control practices were followed during incontinent or catheter care, so the staff did not contaminate other body openings and decreased the risk of UTIs. She stated poor incontinent care could have contributed to Resident #1 and Resident #2's recurrent UTIs. During an interview on 11/25/25 at 3:01 PM, the Administrator stated he expected the nursing staff to ensure the best practices were utilized when performing incontinent or catheter care. The Administrator stated he did not have a clinical background and the administrative nursing staff were responsible for monitoring to ensure infection control practices were utilized during incontinent and catheter care. He stated it was important for infection control issues. Record review of the Nursing Services - Competency Evaluation, dated 11/03/25, reflected CNA A met the performance criteria for incontinent care, with no comments noted. Record review of the Nursing Services – Competency Evaluation, dated 11/03/25, reflected CNA B met the performance criteria for incontinent care, with no comments noted. Record review of the Elimination, Perineal Care policy, effective 10/01/21, reflected To provide cleanliness and comfort to the resident, to prevent infections and skin irritation. The policy did not address infection control practices related to incontinent or catheter care .