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	04/08/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #1) reviewed for quality of care. 1. The facility failed to ensure RN A assessed Resident #1's vital signs and neurological status after his fall on 03/23/26. Vital signs were not checked until the next morning when the family requested the Resident to be sent to the emergency room. Resident #1 took Eliquis (anticoagulant medication). 2. The facility failed to obtain, review, and follow-up on Resident #1's hospital records after his return from the emergency room on [DATE]. These hospital records were not obtained until surveyor intervention. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 04/07/26 at 10:18AM. While the IJ was removed on 04/07/26 at 04:07PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place the residents at risk for decreased quality of care, missed diagnostic results, and harm.Findings included: Record review of Resident #1's face sheet, dated 04/06/26, reflected he was an [AGE] year-old male, admitted to the facility initially on 01/27/24, and most recently readmitted on [DATE]. His diagnoses included dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities), muscle wasting and atrophy of both arms (the loss of muscle mass caused by inactivity, malnutrition, aging, or nerve damage), and chronic lymphocytic leukemia (a slow-growing cancer of the blood and bone marrow, most common in older adults). Record review of Resident #1's quarterly MDS assessment, dated 02/06/26, reflected he was rarely/never understood, and rarely/never understood others. A BIMS score was not obtained because he was rarely/never understood. His cognitive skills for daily decision making were severely impaired. He had a functional limitation in range of motion for all four extremities. He required substantial assistance from staff for rolling left and right in bed. He was completely dependent on staff for eating, oral hygiene, toileting, bathing, dressing, sit to lying, bed to chair transfer, and shower transfer. Record review of Resident #1's Order Summary Report, dated 04/06/26, reflected he had this order:*Eliquis (blood thinner medication) oral tablet 5mg, Give 1 tablet two times a day. The start date was 02/02/26. Record review of Resident #1's care plan, dated with admission date 02/02/26, reflected a focus of I have a history of falls and at risk for increased falls and fractures as evidenced by history of falls, cognitive impairment dementia, and physical impairment left leg fracture. Interventions included may have fall mat, anticipate needs, provide prompt assistance, encourage resident to ask for assistance of staff, and ensure call light is in reach and answer promptly. The care plan further reflected a focus of self-care deficit, needed assistance with activities of daily living related to disease processes. Interventions included bed mobility: the resident requires assistance by staff to turn and reposition in bed and as necessary. May use assist bar to have some independence with bed mobility, and transfer: the resident requires assistance by staff to move between surfaces. Another focus reflected Resident #1 had an actual fall with no injury, 03/23/26 - fall from bed to floor mat. Interventions included Bolster mattress to assist with decrease (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in falls, for no apparent acute injury, determine and address causative factors of the fall, monitor/document/report as needed for 72 hours to doctor for signs or symptoms of pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation, neurological checks, and send to emergency room for evaluation per family request. Record review of a video recording provided to this surveyor by Family Member D, dated 03/23/26 at 08:05PM, this surveyor observed the following:*Resident #1 was lying in bed. His head and left shoulder and left arm were lying off the side of the bed. His legs were lying towards the other side of the bed towards the wall. His left hand was touching the floor mat beside the bed on the floor. Resident #1 raised his left hand and arm, picked up his head and reached towards the bedside dresser next to his bed. His head and shoulders slid further off the bed. His torso began to slide off the bed and his right hand reached towards the floor. His legs followed and he fell to the floor on the floor mat. After this he was lying on his left side on top of the fall mat. The left side of his head and face were touching the floor mat. After this he moved his right arm and head around. The video ended at 08:06PM. Record review of a video recording provided to this surveyor by Family Member D, dated 03/23/26 at 10:25PM, this surveyor observed the following:*Resident #1 was lying on top of the floor mat on the floor next to his bed. He was lying on his left side. LVN B and RN A entered the room. LVN B said We're going to need a [mechanical] lift. RN A then left the room. LVN B had a mechanical lift sling in her hand and crouched near Resident #1. LVN B asked Resident #1 are you hurting?. LVN B attempted to adjust Resident #1's positioning on the floor mat. RN A and CNA C entered the room. RN A then picked up the mechanical lift sling and crouched on the floor near Resident #1. The video ended at 10:28PM. Record review of a video recording provided to this surveyor by Family Member D, dated 03/23/26 at 10:28PM, this surveyor observed the following:*Resident #1 was lying on the top of the floor mat on the floor next to his bed. RN A, LVN B, and CNA C were in his room. RN A was crouched down on the floor next to Resident #1. LVN B was standing by Resident #1's head leaning over him. CNA C was standing at Resident #1's feet. The three staff members moved Resident #1 and assisted him to sit up on his bottom on top of the floor mat. LVN B stood by Resident #1's left side and held under his left arm. CNA C stood on Resident #1's right side and held under his right arm. RN A stood by Resident #1's legs and stabilized Resident #1 as he was sitting up. At this moment all three staff members changed their grip on Resident #1. CNA C put her left hand and arm under Resident #1's right arm. CNA C also put her right hand under Resident #1's left leg. LVN B grabbed under Resident #1's left arm. RN A grabbed Resident #1's left side of his torso and Resident #1's left leg. After this the staff members all counted out loud and lifted Resident #1 back into bed. Record review of a grievance regarding Resident #1's fall on 03/23/26, dated 03/27/26, reflected .Resident laying on fall mat on left side beside bed. No injuries assessed.Nurse (AM) asked why the ambulance was at the facility upon arrival [and] was told by night nurse [Resident #1] rolled out of bed [family member] asked AM nurse to walk [with] her and showed video.Resident experienced fall from bed. family request resident to be sent to ER. ER evaluation no fractures. Monitoring for delayed injuries in place. The grievance was marked that it was not resolved to the satisfaction of all concerned.family upset due to length of time resident laid on floor. [sic] Record review of Resident #1's progress notes, reflected the following notes:*dated 03/24/26 12:30AM, Author: RN A, [Resident #1] was found on the floor by [housekeeper] while he was cleaning the floors on [Resident #1's hall]. [Resident #1] was on the floor next to his bed, fall mats were in place. No injuries noted and family members notified.*dated 03/24/26 06:16AM, Author: LVN C, [Family member] entered facility to check on resident and request that resident be sent to the ER to be checked out post fall. No delayed injuries observed by this nurse. Vitals (121/77 [blood pressure], 91 [heart rate], 98% RA [oxygen saturation on room air], 18 [respirations]). No pain or discomfort noted. No signs of distress noted. EMS called by this nurse. Awaiting arrival. Daughter in residents room and aware of EMS call.*dated 03/24/26 02:12PM, Author: Treatment Nurse, Resident returned from ED. Skin assessment completed.Resident has a small scratch to right buttock.*dated 03/24/26 02:21PM, Author: LVN E, Resident back in facility from (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital, transported by EMS [company] on stretcher, no paperwork on resident from hospital, nurse stated did get IM injection of Rocephin [antibiotic] for elevated WBC and no injuries noted from fall for reason went out to er. No issues noted, cna tried to feed resident lunch but only [took] ensure [protein drink] at this time.*dated 03/25/26 04:16AM, Author: RN A, Resident is sleeping in bed with no sign of pain or distress. Vitals are WNL. Resident is day 2/3 from a fall from his bed. [Neurological] check was started this evening. Monitor groin for redness and abrasion on the right [buttock]. No needs at this time. Record review of Resident #1's skin assessment, dated 03/20/26 at 11:29AM, reflected he did not have any bruise, skin tear, abrasion, laceration, rash, or moisture associated skin damage. He did have an other skin issue identified as a pressure, venous, arterial, diabetic, or surgical wound. The note said See wound assessment - being followed by [wound care company] The assessment was signed by the ADON. Record review of Resident #1's skin assessment, dated 03/24/26 at 02:27PM, reflected he did not have any bruise, skin tear, abrasion, laceration, rash, or moisture associated skin damage. He did have an other skin issue identified as a pressure, venous, arterial, diabetic, or surgical wound. The note said Unstageable pressure wound to right heel 2.5cm x 2cm. ulceration to right metatarsal 2cm x 2cm. self-inflicted scratch to right buttock. Record review of Resident #1's hospital records, dated 03/24/26, reflected: .HPI.this 86 [years] old male presents to ED via EMS.with complaints of fall injury.Patient presents from nursing home after a fall from bed. Per video reviewed bedside with patient's [family member] it appears patient was leaning over the bed to reach something when he fell striking his head on the floor. He fell primarily onto the left side. Patient has a history of cognitive decline and is minimally verbal. He [does not have] any discrete complaints but per EMS [appears] to have pain with manipulation of the shoulders and hips. Per video review by the [family member] the patient was on the floor for about 2 hours. He does take Eliquis.Imaging Report.Exam date: 03/24/26.Exam: [Upper Extremity-Shoulder 2 view bilateral].Impression:1. Elevation of the right humeral head suggesting massive rotator cuff tear. 2. Flattening of the superior lateral aspect of the right humeral head that could represent fracture.3. Elevation of the left humeral head suggesting massive rotator cuff tear. During an interview on 04/06/26 at 09:40AM, Family Member D said Resident #1 was moved to another hall due to the facility treating his room for pests. She said Resident #1 fell after this move and he was found by the housekeeper sweeping. She said she asked the staff about it and the story did not match the camera. She said Resident #1 laid on the floor for almost 3 hours. She said he fell around 8:00PM. She said the staff called her mom around 12AM to report that Resident #1 had rolled out of bed. She said Resident #1's head hit the dresser. She said he had a bruise on his forehead and a red mark on his shoulder. She said he also had a bruise on the side of his head. She said he had a scratch on his back. During an interview on 04/06/26 at 09:57AM, Family Member G said she received a phone call from the nurse after Resident #1 fell. She said the facility staff told her that Resident #1 did not hit his head. She said he did not have a brain bleed, but he did have some bruising, a bruise on his head, and a scratch on his back. She said they pulled him up from the floor and did not check his vital signs, or neurological checks. She said when they called her, they assured her he was okay and he did not hit his head. She said she was not called until around 12:00AM. During an interview on 04/06/26 at 10:23AM, the Administrator said RN A did not do neurological checks or vital signs on Resident #1 after the fall. She said she had not seen the video regarding how the staff members transferred Resident #1 back to bed. She said the DON did see the video. During an interview on 04/06/26 at 11:35AM, the DON said RN A said he had worked in long term care and the hospital before coming to this facility. She said at this point he should have known better regarding not assessing the resident and the improper transfer, and known what to do after a resident fall. During an interview on 04/06/26 at 11:46AM, RN A said on the night Resident #1 fell they did not have a medication aide that night, and there were only two CNAs working as well. He said he was on another hall passing medications when the floor custodian working down Resident #1's hall came and told him that Resident #1 was on the floor. He said Resident #1 was lying on the fall mat and did not appear to be (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hurting. He said he grabbed the other nurse and they did an assessment. He said they transferred Resident #1 back in bed. He said they did not notice any scrapes, cuts, or bruises. He said he did not think Resident #1 hit his head. He said he left to go get the vital sign machine and he was told another resident was falling out of bed. He said he did not make it back down to check Resident #1's vital signs. He said he went back in and checked on him about every 30 mins. He said he called the family. He said the daughter came in about 4:30am. He said he worked the next night and everything was ok at the hospital. He said he did the neurological checks the next night. He said the family said his cheek bone was puffy. He said him and the DON thought it was how the resident was holding his head. He said the ER did clear him of any injuries. He said he did not do vital signs after his fall. He said he also did not do neurological checks after his fall. He said Resident #1 was taking a blood thinner. He said he was not aware Resident #1 was taking a blood thinner at the time of the fall. He said he had only worked at this facility about one week when Resident #1 fell. He said he felt like it was important to get vital signs and neurological checks on an unwitnessed fall. He said he did not think the resident was having a stroke. He said the risk of not getting vital signs or neurological checks was that the resident could have had a change in status and they may not have caught it. He also said they did not use the mechanical lift to transfer the resident back to bed. He said the resident was contracted on his right side and they were unable to get a mechanical lift down that low to the floor. He said Resident #1 could sit up with assistance and they felt that it was safe to transfer him. He said he felt like they transferred him properly because they transferred him by putting the weight on his back. During an interview on 04/06/26 at 12:15PM, LVN B said she recalled Resident #1's fall. She said RN A called for help and she went to go help him. She said she went in the room and Resident #1 was lying on his right side on his right shoulder, with his back towards the bed. She said his head was by the bedside table. She said she asked if he was hurting and he did not respond. She said she felt on his shoulders to see if he was hurting and he did not grimace. She said she thought RN A already checked vital signs and got his physical assessment. She had RN A go get CNA C and they assisted Resident #1 back to bed. She said while she was in the room she did not see RN A get a set of vital signs, do an assessment, or neurological checks. She said she only saw him do a set of vitals when the family had come up to the facility and had RN A sent the resident out to the hospital. She said she thought it was very important for RN A to do vital signs, an assessment, and neurological checks. She said Resident #1 should have been sent out at the time of the fall. She said they manually transferred Resident #1 back to bed by lifting him. She said they had a hand under each arm, and one person grabbed his legs. She said they did not use a mechanical lift because they could not get him moved away from the bed because they could not move the mat or the bed. She said she felt that was the safest way to transfer him. During an interview on 04/06/26 at 12:55PM, CNA C said the nurses asked her to come help after Resident #1 fell. She said when she entered the room Resident #1 was lying on the floor. She said it took 3 of them to pick him up. She said she did not see him fall. She said they changed his brief. She said when they put him back in bed they made sure to position him in the center of the bed so he would not fall. She said she did not see either of the nurses do vital signs. She said RN A was checking Resident #1's skin while they changed his brief. She said they did turn him to his side and they did look at his back. She said she was assigned that hall that night. She said she usually rounds every 2 hours. She said she had not checked on him before he had fallen. She said she had not checked on him until around 10:30 when they found him on the floor. She said they only had 2 aides that evening. She said she had a lot going on and others needed changing. She said if she had checked on him at 8PM she may have found him on the floor and he may not have laid on the floor for two hours. She said she came on shift about 6PM. During an interview on 04/06/26 at 01:47PM, the DON said she was notified of Resident #1's fall and she was told by LVN B that the resident had fallen. She said she received a call the next morning that the family was upset and wanted Resident #1 to be sent out to the hospital. She said she asked if there was any injury and they said no. They sent him to the ER per the family's request. She said she was told by the ADON (continued on next page)

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During an interview on 04/06/26 at 04:19PM, The Director of Rehabilitation watched the video of RN A, LVN B, and CNA C transferring Resident #1 back to bed after his fall on 03/23/26. She said it was an inappropriate transfer. She said they should have used a mechanical lift or a gait belt. She said she did not know if it was possible for the inappropriate transfer to have caused a rotator cuff tear. She said they should have used a gait at least when they transferred Resident #1 back to bed. During an interview on 04/06/26 at 04:25PM, the Facility's Nurse Practitioner was present in the facility. She said the staff just notified her of the finding in the hospital paperwork for Resident #1 that was missed. She said she was going to order a follow up MRI. She said she expected the facility staff to have gotten the hospital paperwork when he came back from the hospital. She said if she were told of the significant finding in Resident #1's diagnostic scans when he returned to the facility, she would have ordered a follow up scan and an orthopedic appointment. During an interview on 04/07/26 at 07:27AM, Family Member D said Resident #1 did not have a history of any rotator cuff tears. She said she was not aware the x-ray at the hospital suggested he may have 2 rotator cuff tears and a fracture. She said the hospital did not mention that to her, and they only asked if he had any history of shoulder injury or surgery. She said he did not. She said he has not exhibited signs of increased pain since the fall. She said he grimaced when he was moved but that is normal for him. During an interview on 04/07/26 at 07:57AM, RN A said on the night of Resident #1's fall, his shift started around 6PM and he did not check on Resident #1 prior to his fall. He said the first time he saw Resident #1 that shift was when he was already on the floor. He said it would have been later than that if he hadn't been made aware that the resident was on the floor. He said he was busy passing medications. He said they did not have a medication aide that evening. He said there were two nurses and two aides working. He said the last time he had to work like that without a medication aide it took him until 1AM to finish passing medications to his residents. During an interview on 04/07/26 at 09:20AM, RN A said he did not contact the doctor after Resident #1 fell or when he was sent out to the hospital. During an interview on 04/07/26 at 10:30AM, Family Member D said if she would have been aware of the abnormal finding of the x-ray regarding a possible fracture and torn rotator cuffs for Resident #1, she would have had the facility send him back to the hospital, or set up a follow up appointment, or get follow up imaging done. During an interview on 04/07/26 at 11:21AM, Family Member F said she was a family member of Resident #1's. She said she thought that Resident #1 may have had a little decreased range of motion in his arms since the fall. She also said Resident #1 hides his pain well, but she thought he had an increase in pain since his fall. She mentioned that he has a facial grimace he makes when he is transferred. She said she was not present when the other family members came up to the facility and had him sent to the hospital. During an interview on 04/07/26 at 03:30PM, LVN B said she did not call the family after Resident #1's fall. She said she may have notified the Nurse Practitioner, but she was not sure. She said RN A called the family. Record review of the Facility's policy, Risk Management, dated 03-01-17, reflected: .3. Licensed nurse will complete a fall investigation report after every fall to include vital signs, pain assessment, and environmental assessment. There may be instances where residents have multiple falls in a day and a new incident report will be completed with each fall. A head-to-toe assessment must be completed at the time of the incident. Resident will continue to be assessed every shift for 72 hours.4. Licensed nurse will notify physician and responsible party.13. A (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	neurological check form is to be completed for any fall involving the head or any unwitnessed fall. Record review of the prescribing information for Eliquis (anticoagulant drug), revised April 2025, reflected the following: .5.2 BleedingELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding Advise patients of signs and symptoms of blood loss and to report them immediately or go to an emergency room 17 PATIENT COUNSELING INFORMATION Advise patients of the following: That it might take longer than usual for bleeding to stop and they may bruise or bleed more easily when treated with ELIQUIS. Advise patients about how to recognize bleeding or symptoms of hypovolemia (low blood volume) and of the urgent need to report any unusual bleeding to their physician MEDICATION GUIDE How should I take ELIQUIS? Call your healthcare provider .right away if you fall or injure yourself, especially if you hit your head. Your healthcare provider .may need to check you The Administrator was notified of an IJ on 04/07/26 at 10:18AM and was given a copy of the IJ template and a Plan of Removal (POR) was requested. An updated IJ template was provided on 04/16/26 at 01:58PM. The Plan of Removal was accepted on 04/07/26 at 01:36PM and included the following: [Facility name] [Facility address]ˆ April 7, 2026 ˆ Attention: Program Manager Re: Plan of Removal of Immediate Jeopardy - F689 This letter serves as the Plan of Removal for the Immediate Jeopardy identified at [Facility name] (the Facility) on April 7, 2026, at 10:25am. The corrective actions outlined below have been implemented to address the alleged deficient practices. Resident #1 was discharged from the Facility to an Acute Care Facility on March 24, 2026 following the fall on March 23, 2026. On April 7,2026 Resident #1's physician and family were notified of the Acute Care Facility's findings from the March 24, 2026 visit by the Director of Clinical Operations (DCO). On April 7, 2026, at 11am, re-education for Executive Director of Operations (EDO) and DCO on Incident/Accident investigations and review during the routine Clinical Systems meeting conducted by Regional [NAME] President of Operations. Re-education provided for all Clinical Staff was initiated at 11:00am on April 7, 2026 by the EDO and/or designee regarding 2-hour routine rounding on assigned halls, Titled Routine Rounding. DCO re-educated all floor nurses on post fall assessment protocols including proper notifications to families and physicians. Assessment criteria outlines vitals assessments and Neuro checks post fall. Re-education titled: Post Fall Assessment. Re-education completed on April 7, 2026.Education will be on going and no employee will be permitted to start his/her next shift until re-education is completed. Re-education audience is all clinical team members and emphasized proper response to resident who has experienced a fall, required assessment protocols, and immediate investigation and reporting of all falls to the DCO and/or designee. Staff demonstrated competency through verbal questioning related to the in-service topic at the time of re-education. On April 7, 2026, at 11:00am Incident/Accident audit was initiated and completed by DCO to validate accuracy and investigation into the incidents and accidents. No concerns notated. The Medical Director was notified of the Immediate Jeopardy on April 7, 2026, and participated in development of this plan through an abbreviated Quality Assurance process. The next scheduled QA meeting is set for April 24, 2026, at 12:00 p.m. This Plan of Removal was implemented on April 7, 2026, and compliance will be monitored through direct observation by the Executive Director of Operations and the Director of Clinical Services. Sincerely, [Facility name][Facility address] The surveyor's verification of the Plan of Removal on 04/07/26 was as follows:Record review of an undated checklist reflected the facility had initiated and completed an incident/accident audit to validate accuracy and investigation into the incidents and accidents. Items verified included whether vital signs where checked, neurological checks were completed, responsible party notified, physician notified, and whethe

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	675602	A. Building B. Wing	04/08/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible, and each resident received adequate supervision to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and hazards in that: 1. On 03/23/26, the facility failed to ensure that Resident #1 did not lay on the floor for approximately 2 hours and 20 minutes after falling out of bed. 2. The facility failed to ensure that RN A, LVN B, and CNA C appropriately transferred Resident #1 back to bed post fall. 3. The facility failed to ensure that RN A and CNA C monitored Resident #1 every 2 hours. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 04/07/26 at 10:18AM. While the IJ was removed on 04/07/26 at 04:07PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.These deficient practices could place the residents at risk for serious harm, serious injury, or death.Findings included: Record review of Resident #1's face sheet, dated 04/06/26, reflected he was an [AGE] year-old male, admitted to the facility initially on 01/27/24, and most recently readmitted on [DATE]. His diagnoses included dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities), muscle wasting and atrophy of both arms (the loss of muscle mass caused by inactivity, malnutrition, aging, or nerve damage), and chronic lymphocytic leukemia (a slow-growing cancer of the blood and bone marrow, most common in older adults). Record review of Resident #1's quarterly MDS assessment, dated 02/06/26, reflected he was rarely/never understood, and rarely/never understood others. A BIMS score was not obtained because he was rarely/never understood. His cognitive skills for daily decision making were severely impaired. He had a functional limitation in range of motion for all four extremities. He required substantial assistance from staff for rolling left and right in bed. He was completely dependent on staff for eating, oral hygiene, toileting, bathing, dressing, sit to lying, bed to chair transfer, and shower transfer. Record review of Resident #1's Order Summary Report, dated 04/06/26, reflected he had this order:*Eliquis (blood thinner medication) oral tablet 5mg, Give 1 tablet two times a day. The start date was 02/02/26. Record review of Resident #1's care plan, dated with admission date 02/02/26, reflected a focus of I have a history of falls and at risk for increased falls and fractures as evidenced by history of falls, cognitive impairment dementia, and physical impairment left leg fracture. Interventions included may have fall mat, anticipate needs, provide prompt assistance, encourage resident to ask for assistance of staff, and ensure call light is in reach and answer promptly. The care plan further reflected a focus of self-care deficit, needed assistance with activities of daily living related to disease processes. Interventions included bed mobility: the resident requires assistance by staff to turn and reposition in bed and as necessary. May use assist bar to have some independence with bed mobility, and transfer: the resident requires assistance by staff to move between surfaces. Another focus reflected Resident #1 had an actual fall with no injury, 03/23/26 - fall from bed to floor mat. Interventions included Bolster mattress to assist with decrease in falls, for no apparent acute injury, determine and address causative factors of the fall, monitor/document/report as needed for 72 hours to doctor for signs or symptoms of pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation, neurological checks, and send to emergency room for evaluation per family request. Record review of a video recording provided to this surveyor by Family Member D, dated 03/23/26 at 08:05PM, this surveyor observed the following:*Resident #1 was lying in bed. His head and left shoulder and left arm were lying off the side of the bed. His legs were lying towards the other side of the bed towards the wall. His left hand was touching the floor mat beside the bed on the floor. Resident #1 raised his left hand and arm, picked up his head and reached towards the bedside (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dresser next to his bed. His head and shoulders slid further off the bed. His torso began to slide off the bed and his right hand reached towards the floor. His legs followed and he fell to the floor on the floor mat. After this he was lying on his left side on top of the fall mat. The left side of his head and face were touching the floor mat. After this he moved his right arm and head around. The video ended at 08:06PM. Record review of a video recording provided to this surveyor by Family Member D, dated 03/23/26 at 10:25PM, this surveyor observed the following:*Resident #1 was lying on top of the floor mat on the floor next to his bed. He was lying on his left side. LVN B and RN A entered the room. LVN B said We're going to need a [mechanical] lift. RN A then left the room. LVN B had a mechanical lift sling in her hand and crouched near Resident #1. LVN B asked Resident #1 are you hurting?. LVN B attempted to adjust Resident #1's positioning on the floor mat. RN A and CNA C entered the room. RN A then picked up the mechanical lift sling and crouched on the floor near Resident #1. The video ended at 10:28PM. Record review of a video recording provided to this surveyor by Family Member D, dated 03/23/26 at 10:28PM, this surveyor observed the following:*Resident #1 was lying on the top of the floor mat on the floor next to his bed. RN A, LVN B, and CNA C were in his room. RN A was crouched down on the floor next to Resident #1. LVN B was standing by Resident #1's head leaning over him. CNA C was standing at Resident #1's feet. The three staff members moved Resident #1 and assisted him to sit up on his bottom on top of the floor mat. LVN B stood by Resident #1's left side and held under his left arm. CNA C stood on Resident #1's right side and held under his right arm. RN A stood by Resident #1's legs and stabilized Resident #1 as he was sitting up. At this moment all three staff members changed their grip on Resident #1. CNA C put her left hand and arm under Resident #1's right arm. CNA C also put her right hand under Resident #1's left leg. LVN B grabbed under Resident #1's left arm. RN A grabbed Resident #1's left side of his torso and Resident #1's left leg. After this the staff members all counted out loud and lifted Resident #1 back into bed. Record review of a grievance regarding Resident #1's fall on 03/23/26, dated 03/27/26, reflected .Resident laying on fall mat on left side beside bed. No injuries assessed.Nurse (AM) asked why the ambulance was at the facility upon arrival [and] was told by night nurse [Resident #1] rolled out of bed [family member] asked AM nurse to walk [with] her and showed video.Resident experienced fall from bed. family request resident to be sent to ER. ER evaluation no fractures. Monitoring for delayed injuries in place. The grievance was marked that it was not resolved to the satisfaction of all concerned.family upset due to length of time resident laid on floor. [sic] Record review of Resident #1's progress notes, reflected the following notes:*dated 03/24/26 12:30AM, Author: RN A, [Resident #1] was found on the floor by [housekeeper] while he was cleaning the floors on [Resident #1's hall]. [Resident #1] was on the floor next to his bed, fall mats were in place. No injuries noted and family members notified.*dated 03/24/26 06:16AM, Author: LVN C, [Family member] entered facility to check on resident and request that resident be sent to the ER to be checked out post fall. No delayed injuries observed by this nurse. Vitals (121/77 [blood pressure], 91 [heart rate], 98% RA [oxygen saturation on room air], 18 [respirations]). No pain or discomfort noted. No signs of distress noted. EMS called by this nurse. Awaiting arrival. Daughter in residents room and aware of EMS call.*dated 03/24/26 02:12PM, Author: Treatment Nurse, Resident returned from ED. Skin assessment completed.Resident has a small scratch to right buttock.*dated 03/24/26 02:21PM, Author: LVN E, Resident back in facility from hospital, transported by EMS [company] on stretcher, no paperwork on resident from hospital, nurse stated did get IM injection of Rocephin [antibiotic] for elevated WBC and no injuries noted from fall for reason went out to er. No issues noted, cna tried to feed resident lunch but only [took] ensure [protein drink] at this time.*dated 03/25/26 04:16AM, Author: RN A, Resident is sleeping in bed with no sign of pain or distress. Vitals are WNL. Resident is day 2/3 from a fall from his bed. [Neurological] check was started this evening. Monitor groin for redness and abrasion on the right [buttock]. No needs at this time. Record review of Resident #1's skin assessment, dated 03/20/26 at 11:29AM, reflected he did not have any bruise, skin tear, abrasion, laceration, rash, or moisture associated skin damage. He did have an other skin issue identified as a pressure, venous, arterial, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diabetic, or surgical wound. The note said See wound assessment - being followed by [wound care company] The assessment was signed by the ADON. Record review of Resident #1's skin assessment, dated 03/24/26 at 02:27PM, reflected he did not have any bruise, skin tear, abrasion, laceration, rash, or moisture associated skin damage. He did have an other skin issue identified as a pressure, venous, arterial, diabetic, or surgical wound. The note said Unstageable pressure wound to right heel 2.5cm x 2cm. ulceration to right metatarsal 2cm x 2cm. self-inflicted scratch to right buttock. Record review of Resident #1's hospital records, dated 03/24/26, reflected: .HPI.this 86 [years] old male presents to ED via EMS.with complaints of fall injury.Patient presents from nursing home after a fall from bed. Per video reviewed bedside with patient's [family member] it appears patient was leaning over the bed to reach something when he fell striking his head on the floor. He fell primarily onto the left side. Patient has a history of cognitive decline and is minimally verbal. He [does not have] any discrete complaints but per EMS [appears] to have pain with manipulation of the shoulders and hips. Per video review by the [family member] the patient was on the floor for about 2 hours. He does take Eliquis.Imaging Report.Exam date: 03/24/26.Exam: [Upper Extremity-Shoulder 2 view bilateral].Impression:1. Elevation of the right humeral head suggesting massive rotator cuff tear. 2. Flattening of the superior lateral aspect of the right humeral head that could represent fracture.3. Elevation of the left humeral head suggesting massive rotator cuff tear. During an interview on 04/06/26 at 09:40AM, Family Member D said Resident #1 was moved to another hall due to the facility treating his room for pests. She said Resident #1 fell after this move and he was found by the housekeeper sweeping. She said she asked the staff about it and the story did not match the camera. She said Resident #1 laid on the floor for almost 3 hours. She said he fell around 8:00PM. She said the staff called her mom around 12AM to report that Resident #1 had rolled out of bed. She said Resident #1's head hit the dresser. She said he had a bruise on his forehead and a red mark on his shoulder. She said he also had a bruise on the side of his head. She said he had a scratch on his back. During an interview on 04/06/26 at 09:57AM, Family Member G said she received a phone call from the nurse after Resident #1 fell. She said the facility staff told her that Resident #1 did not hit his head. She said he did not have a brain bleed, but he did have some bruising, a bruise on his head, and a scratch on his back. She said they pulled him up from the floor and did not check his vital signs, or neurological checks. She said when they called her, they assured her he was okay and he did not hit his head. She said she was not called until around 12:00AM. During an interview on 04/06/26 at 10:23AM, the Administrator said RN A did not do neurological checks or vital signs on Resident #1 after the fall. She said she had not seen the video regarding how the staff members transferred Resident #1 back to bed. She said the DON did see the video. During an interview on 04/06/26 at 11:35AM, the DON said RN A said he had worked in long term care and the hospital before coming to this facility. She said at this point he should have known better regarding not assessing the resident and the improper transfer, and known what to do after a resident fall. During an interview on 04/06/26 at 11:46AM, RN A said on the night Resident #1 fell they did not have a medication aide that night, and there were only two CNAs working as well. He said he was on another hall passing medications when the floor custodian working down Resident #1's hall came and told him that Resident #1 was on the floor. He said Resident #1 was lying on the fall mat and did not appear to be hurting. He said he grabbed the other nurse and they did an assessment. He said they transferred Resident #1 back in bed. He said they did not notice any scrapes, cuts, or bruises. He said he did not think Resident #1 hit his head. He said he left to go get the vital sign machine and he was told another resident was falling out of bed. He said he did not make it back down to check Resident #1's vital signs. He said he went back in and checked on him about every 30 mins. He said he called the family. He said the daughter came in about 4:30am. He said he worked the next night and everything was ok at the hospital. He said he did the neurological checks the next night. He said the family said his cheek bone was puffy. He said him and the DON thought it was how the resident was holding his head. He said the ER did clear him of any injuries. He said he did not do vital signs after his fall. He (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said he also did not do neurological checks after his fall. He said Resident #1 was taking a blood thinner. He said he was not aware Resident #1 was taking a blood thinner at the time of the fall. He said he had only worked at this facility about one week when Resident #1 fell. He said he felt like it was important to get vital signs and neurological checks on an unwitnessed fall. He said he did not think the resident was having a stroke. He said the risk of not getting vital signs or neurological checks was that the resident could have had a change in status and they may not have caught it. He also said they did not use the mechanical lift to transfer the resident back to bed. He said the resident was contracted on his right side and they were unable to get a mechanical lift down that low to the floor. He said Resident #1 could sit up with assistance and they felt that it was safe to transfer him. He said he felt like they transferred him properly because they transferred him by putting the weight on his back. During an interview on 04/06/26 at 12:15PM, LVN B said she recalled Resident #1's fall. She said RN A called for help and she went to go help him. She said she went in the room and Resident #1 was lying on his right side on his right shoulder, with his back towards the bed. She said his head was by the bedside table. She said she asked if he was hurting and he did not respond. She said she felt on his shoulders to see if he was hurting and he did not grimace. She said she thought RN A already checked vital signs and got his physical assessment. She had RN A go get CNA C and they assisted Resident #1 back to bed. She said while she was in the room she did not see RN A get a set of vital signs, do an assessment, or neurological checks. She said she only saw him do a set of vitals when the family had come up to the facility and had RN A sent the resident out to the hospital. She said she thought it was very important for RN A to do vital signs, an assessment, and neurological checks. She said Resident #1 should have been sent out at the time of the fall. She said they manually transferred Resident #1 back to bed by lifting him. She said they had a hand under each arm, and one person grabbed his legs. She said they did not use a mechanical lift because they could not get him moved away from the bed because they could not move the mat or the bed. She said she felt that was the safest way to transfer him. During an interview on 04/06/26 at 12:55PM, CNA C said the nurses asked her to come help after Resident #1 fell. She said when she entered the room Resident #1 was lying on the floor. She said it took 3 of them to pick him up. She said she did not see him fall. She said they changed his brief. She said when they put him back in bed they made sure to position him in the center of the bed so he would not fall. She said she did not see either of the nurses do vital signs. She said RN A was checking Resident #1's skin while they changed his brief. She said they did turn him to his side and they did look at his back. She said she was assigned that hall that night. She said she usually rounds every 2 hours. She said she had not checked on him before he had fallen. She said she had not checked on him until around 10:30 when they found him on the floor. She said they only had 2 aides that evening. She said she had a lot going on and others needed changing. She said if she had checked on him at 8PM she may have found him on the floor and he may not have laid on the floor for two hours. She said she came on shift about 6PM. During an interview on 04/06/26 at 01:47PM, the DON said she was notified of Resident #1's fall and she was told by LVN B that the resident had fallen. She said she received a call the next morning that the family was upset and wanted Resident #1 to be sent out to the hospital. She said she asked if there was any injury and they said no. They sent him to the ER per the family's request. She said she was told by the ADON that the family had come back and was upset because he had laid on the floor for a long time. She said she reviewed the records, and the neurological checks and vital sign checks were not completed. She said she called RN A and asked him about it and notified him that the policy was for vital signs and neurological checks to be completed after a fall. She said she had him come in prior to his next shift and did a one on one regarding this situation and what was expected. She said RN A told her that he did go in and he did do an assessment but did not check vital signs or neurological checks. She said he did not document any of this. She said when the resident returned from the hospital he did not have any new injuries. She said she told RN A to start the neurological checks once Resident #1 had returned to the facility. She said she did a fall in-service with all the nurses immediately. She said she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	04:19PM, The Director of Rehabilitation watched the video of RN A, LVN B, and CNA C transferring Resident #1 back to bed after his fall on 03/23/26. She said it was an inappropriate transfer. She said they should have used a mechanical lift or a gait belt. She said she did not know if it was possible for the inappropriate transfer to have caused a rotator cuff tear. She said they should have used a gait at least when they transferred Resident #1 back to bed. During an interview on 04/06/26 at 04:25PM, the Facility's Nurse Practitioner was present in the facility. She said the staff just notified her of the finding in the hospital paperwork for Resident #1 that was missed. She said she was going to order a follow up MRI. She said she expected the facility staff to have gotten the hospital paperwork when he came back from the hospital. She said if she were told of the significant finding in Resident #1's diagnostic scans when he returned to the facility, she would have ordered a follow up scan and an orthopedic appointment. During an interview on 04/07/26 at 07:27AM, Family Member D said Resident #1 did not have a history of any rotator cuff tears. She said she was not aware the x-ray at the hospital suggested he may have 2 rotator cuff tears and a fracture. She said the hospital did not mention that to her, and they only asked if he had any history of shoulder injury or surgery. She said he did not. She said he has not exhibited signs of increased pain since the fall. She said he grimaced when he was moved but that is normal for him. During an interview on 04/07/26 at 07:57AM, RN A said on the night of Resident #1's fall, his shift started around 6PM and he did not check on Resident #1 prior to his fall. He said the first time he saw Resident #1 that shift was when he was already on the floor. He said it would have been later than that if he hadn't been made aware that the resident was on the floor. He said he was busy passing medications. He said they did not have a medication aide that evening. He said there were two nurses and two aides working. He said the last time he had to work like that without a medication aide it took him until 1AM to finish passing medications to his residents. During an interview on 04/07/26 at 09:20AM, RN A said he did not contact the doctor after Resident #1 fell or when he was sent out to the hospital. During an interview on 04/07/26 at 10:30AM, Family Member D said if she would have been aware of the abnormal finding of the x-ray regarding a possible fracture and torn rotator cuffs for Resident #1, she would have had the facility send him back to the hospital, or set up a follow up appointment, or get follow up imaging done. During an interview on 04/07/26 at 11:21AM, Family Member F said she was a family member of Resident #1's. She said she thought that Resident #1 may have had a little decreased range of motion in his arms since the fall. She also said Resident #1 hides his pain well, but she thought he had an increase in pain since his fall. She mentioned that he has a facial grimace he makes when he is transferred. She said she was not present when the other family members came up to the facility and had him sent to the hospital. During an interview on 04/07/26 at 03:30PM, LVN B said she did not call the family after Resident #1's fall. She said she may have notified the Nurse Practitioner, but she was not sure. She said RN A called the family. Record review of the facility's policy, Safe Lifting and Movement of Residents, last revised July 2017, reflected: .2. Manual lifting of residents shall be eliminated when feasible .5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary The Administrator was notified of an IJ on 04/07/26 at 10:18AM and was given a copy of the IJ template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 04/07/26 at 01:36PM and included the following: [Facility name] [Facility address]ˆ April 7, 2026 ˆ Attention: Program Manager Re: Plan of Removal of Immediate Jeopardy - F689 This letter serves as the Plan of Removal for the Immediate Jeopardy identified at [Facility name] (the Facility) on April 7, 2026, at 10:25am. The corrective actions outlined below have been implemented to address the alleged deficient practices. Resident #1 was discharged from the Facility to an Acute Care Facility on March 24, 2026 following the fall on March 23, 2026. On April 7,2026 Resident #1's physician and family were notified of the Acute Care Facility's findings from the March 24, 2026 visit by the Director of Clinical Operations (DCO). On April 7, 2026, at 11am, re-education for Executive Director of Operations (EDO) and DCO on Incident/Accident investigations and review during the routine Clinical Systems meeting conducted by Regional [NAME] President of Operations. (continued on next page)

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	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Gilmer	623 Hwy 155n Gilmer, TX 75644

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Re-education provided for all Clinical Staff was initiated at 11:00am on April 7, 2026 by the EDO and/or designee regarding 2-hour routine rounding on assigned halls, Titled Routine Rounding. DCO re-educated all floor nurses on post fall assessment protocols including proper notifications to families and physicians. Assessment criteria outlines vitals assessments and Neuro checks post fall. Re-education titled: Post Fall Assessment. Re-education completed on April 7, 2026. RN A, LVN B, and CNA C were provided 1:1 transfer re-education from the Rehab Director on April 7, 2026. On April 7, 2026, All Clinical Team members were re-educated on resident transfer procedures, validating and utilizing appropriate mechanics that align with the resident's plan of care to ensure the safety of all, and the importance of Gait Belt Utilization. Education for resident transfers including proper utilization of equipment, [mechanical] lift, when a resident is on the floor. Education will be on going and no employee will be permitted to start his/her next shift until re-education is completed. Re-education audience is all clinical team members and emphasized proper response to resident who has experienced a fall, required assessment protocols, and immediate investigation and reporting of all falls to the DCO and/or designee. Staff demonstrated competency through verbal questioning related to the in-service topic at the time of re-education. On April 7, 2026, at 11:00am Incident/Accident audit was initiated and completed by DCO to validate accuracy and investigation into the incidents and accidents. No concerns notated. The Medical Director was notified of the Immediate Jeopardy on April 7, 2026, and participated in development of this plan through an abbreviated Quality Assurance process. The next scheduled QA meeting is set for April 24, 2026, at 12:00 p.m. This Plan of Removal was implemented on April 7, 2026, and compliance will be monitored through direct observation by the Executive Director of Operations and the Director of Clinical Services. Sincerely, [Facility name][Facility address] The surveyor's verification of the Plan of Removal on 04/07/26 was as follows:Record review of an undated checklist reflected the facility had initiated and completed an incident/accident audit to validate accuracy and investigation into the incidents and accidents. Items verified included whether vital signs where checked, neurological checks were completed, responsible party notified, physician notified, and whether hospital records were received if the resident went to the hospital. Record review of an undated monitoring sheet, reflected the facility had initiated a monitoring form for review of resident falls and included checks for vital signs, neurological checks, responsible party notified, physician notified, 24-hour report updated, post fall interventions implemented, ER visit required, record received from the ER, and whether the nurse had reviewed the records. Record review of an undated QAPI Project document, Improving Post-Fall Assessment Completion & Documentation, reflected that the facility had initiated a QAPI plan regarding post-fall assessment and documentation.During interviews on 04/07/26 from 01:52PM through 04:03PM the following staff were interviewed:LVN E, MA H, LVN K, CNA L, CNA M, the MDS Coordinator, CNA N, CNA O, the Treatment Nurse, CNA P, LVN Q, LVN, R, LVN S, LVN B, LVN T, RN A, LVN U, CNA V, CNA W, CNA X, CNA Y, CNA Z, CNA AA, CNA BB, CNA CC, CNA DD, CNA EE, MA FF, MA GG, RN HH, RN KK, the DON, the ADON, and the Administrator