

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 4 residents (Resident #2) reviewed for resident neglect. The facility failed to ensure Resident #2 was given lunch and dinner on 06/13/2026. The facility failed to ensure Resident #2 was provided with incontinent care and turning and repositioning every 2 hours on 06/13/2026. These failures could result in pressure injuries, weight loss, infections, psychosocial harm, and a decreased quality of life. Findings included: Record review of Resident #2's face sheet dated 06/17/2026, indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia mild without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without any behaviors or disturbances), atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow), and methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere (a type of bacteria that causes skin infections and is resistant to many antibiotics). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated he was rarely/never understood by others and rarely/never understood others. The BIMS interview could not be completed due to Resident #2 rarely/never understood by others and rarely/never understood others. The MDS assessment indicated Resident #2 had a short-term and long-term memory problem. The MDS assessment indicated Resident #2 was dependent on staff for all ADLs. Record review of Resident #2's care plan with a target date of 08/03/2026 indicated he required assistance with his ADLs. Resident #2 required assistance by staff for dressing, eating, personal hygiene, transfers, and toilet use. Resident #2 was at risk for skin breakdown with interventions to monitor nutritional status and serve diet as ordered. Resident #2 was at risk for deficient fluid volume and for altered nutritional status with interventions to encourage 6-8 glasses of fluid intake and to offer fluids he liked as much as possible. Resident #2 was incontinent and was at risk for skin breakdown and needed to be monitored for incontinence every 2 hours and as needed. During an observation of video footage dated 06/13/2026 from 10:51 AM- 11:02 PM revealed:10:51 AM, CNA C and CNA K provided incontinent care to Resident #2, changed his shirt (shirt was changed to a white shirt), and positioned him on his left side. No fluids were offered and none observed on his overbed table.12:59 PM, CNA G was observed entering Resident #2's room, she set his meal tray down on his over-bed table, which was located out of Resident #2's reach, and walked out of the room. No attempts were made to assist him, offer him fluids, or reposition him. 3:51 PM, CNA C entered Resident #2's room, looked at his covered lunch tray, and said, Did she not try to feed him?. She took the cover off the plate, looked at it, covered it back up, and walked out of the room. CNA C could be heard talking to someone in the hallway but the audio was inaudible due to Resident #2's TV playing loudly. No attempts were made to assist him with his meal, offer him fluids, or reposition him. Resident #2 was still on his left side.4:10 PM, CNA K provided incontinent care to Resident #2 and transferred him to his wheelchair with assistance of CNA C. Fluids were not offered and Resident #2 was still lying towards his left side prior to being transferred. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they could go hungry and it could be considered neglect. During an interview on 06/17/2026 at 5:26 PM, LVN A said she provided care to Resident #2 and was the charge nurse for Resident #2 on Saturday, 06/13/2026. LVN A said CNA G placed Resident #2's tray on his over-bed table, and CNA C picked up Resident #2's tray. LVN A said they were short on 06/13/2026, and she had notified the ADON and she told her she could not find replacements. LVN A said CNA G left early in the shift and they were left with 3 CNAs, CNA H, CNA C, and CNA K. LVN A said the video showed that the CNAs did not attempt to assist Resident #2 with his lunch meal. LVN A said she did not know who gave the residents their dinner trays because she left at 5:40 PM and the dinner trays were not ready to be passed out at that time. LVN A said CNA C did not report to her that Resident #2 was not assisted with his meal or that he refused lunch. LVN A said she was not aware Resident #2 was not given his lunch meal. LVN A said the CNAs should be checking on the residents to see if they needed to be changed and repositioning them every 2 hours. LVN A said the CNAs should offer the residents fluids when they were doing their rounds at least every 2 hours. LVN A said Resident #2 went without being changed and repositioned and without fluids and food for too long and it was bad for his skin and could be considered neglect. During an interview on 06/17/2026 at 6:18 PM, the ADON said on Saturday, 06/13/2026, she worked as a CNA for the 6 PM-6 AM shift. The ADON said it was around midnight one of Resident #2's family members arrived to the facility and stated Resident #2 had not been fed lunch or dinner and was not provided care for extended lengths of time. The ADON said this allegation could be considered neglect. She said she did not know who she should report to because she thought the Interim DCO, who was currently the Abuse Coordinator, was not available. The ADON said CNA M was responsible for giving Resident #2 his dinner, so she asked CNA M if she had given Resident #2 his dinner and she told her she had. The ADON said she did not pass out any dinner trays. The ADON said she thought CNA M gave Resident #2 his dinner. The ADON said she did not check to see if Resident #2 had lunch, and she did not further look into what happened. The ADON said when Resident #2's family member notified her of him not receiving his lunch Resident #2's family member had already given Resident #2 some beans. The ADON said the CNAs should be checking and turning the residents and offering them fluids during their rounds at least every 2 hours. The ADON said the residents not being assisted with their meals could result in weight loss and cause issues with wound healing. During an interview on 06/17/2026 at 6:48 PM, the Interim DCO said he was not aware of Resident #2 not receiving lunch and dinner, and Resident #2's representative had not brought any concerns to him. He said the ADON should have investigated when Resident #2's representative reported to her he had not been given lunch or dinner and there were complaints regarding the lack of care he received. The Interim DCO said the ADON should have notified him of the allegation made. He said the previous DON's last day was 05/26/2026 and the previous administrator's last day was 06/05/2026. He said the process that should have been followed by the ADON was if a resident representative reported to her the resident was not fed that should have prompted somebody to take it seriously, and the staff involved should have been suspended pending investigation and it should have been reported according to the guidelines. He said he expected the staff to check on the residents, reposition them, and offer fluids every time they went into the residents' rooms. He said Resident #2 was denied his nutritional requirements for the day and was at risk for dehydration, low blood sugar, and the ADON not reporting had the potential to harm every resident because they deprived the resident of the determination of what happened. During an interview on 06/17/2026 at 7:18 PM, CNA G said they were short staffed on Saturday, 06/13/2026, and she initially started working on Resident #2's hall but then was switched to a different hall and CNA C was supposed to provide care to Resident #2. CNA G said she gave Resident #2 his breakfast, and then for lunch she passed his tray but did not go back to feed him. She said it was wacky and there was a lot going on and she got switched halls. CNA G said she was switched halls way before lunch, and CNA C was responsible for Resident #2's hall. CNA G said she got off around 3 PM, so she was not present for dinner. CNA C said they were supposed to round on the residents every 2 hours, check them to see if (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they needed to be changed, offer them fluids, and reposition them. CNA C said Resident #2 could be dehydrated or have malnutrition. CNA G said not providing care and not assisting the residents with their meals could be considered neglect. During an interview on 06/18/2026 at 10:40 AM, CNA M said Saturday, 06/13/2026, she worked all over the building on the 6 PM-6 AM shift. She said it was just her and the ADON as CNAs that night. She said she did not assist any residents with their meals. She said she thought she saw the ADON passing out meal trays on Resident #2's hall. CNA M said she was not aware Resident #2 did not receive his dinner tray. CNA M said not providing meals to the residents could be considered neglect. During an interview on 06/18/2026 at 11:17 AM, CNA K said on 06/13/2026, CNA G was assigned to Resident #2's hall. CNA K said CNA G left at 2 PM and she and CNA C were assigned to care for Resident #2. CNA K said CNA G gave Resident #2 his lunch tray, so she was responsible for assisting him with his meal. CNA K said CNA C picked up Resident #2's tray but she was not aware he did not eat. CNA K said she did not know who gave the residents their dinner trays because she was leaving when they started passing out the dinner trays. CNA K said CNA M and the ADON were the ones who worked the night shift on 06/13/2026, and they gave out the dinner trays. CNA K said not giving the residents their meals could be considered neglect and the residents could get sick. During an interview on 06/18/2026 at 11:49 AM, CNA H said on Saturday, 06/13/2026, she did not provide care to Resident #2. CNA H said during her shift the lunch meal was served, but she was gone when the dinner meal was served. CNA H said CNA G was responsible for giving Resident #2 his lunch. During an interview on 06/18/2026 at 1:53 PM, the Regional [NAME] President said he expected for the residents to be assisted with their meals. He said the staff should be checking when they are rounding to ensure the residents have fluids within reach or offer them fluids when rounding routinely. He said he was not aware Resident #2 did not receive his lunch or dinner meal or that he was not repositioned or offered fluids for extended periods of time. He said that was unacceptable and it was considered incompetency. He said when the ADON received the complaint from Resident #2's representative she should have notified him or the Interim DCO so they could resolve the issue. He said this could affect the residents and cause dehydration and malnutrition. Record review of the facility's policy, Abuse, revised 01/01/2023, indicated, The purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect. Each employee receives the standards of conduct which includes the standard for prohibiting abuse or neglect of a resident, and the reporting of any suspected abuse or neglect of a resident.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 3 residents (Resident #3) reviewed for ADLs. The facility failed to ensure Resident #3 received bathing as scheduled for the months of May 2026 and June 2026. This failure could place residents at risk of not receiving needed services and care, decreased self-esteem, and a decreased quality of life. Findings included: Record review of Resident #3's face sheet dated 06/18/2026 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs) and muscle weakness. Record review of Resident #3's Quarterly MDS assessment dated [DATE] indicated she understood others and others usually understood her. Resident #3's BIMS was a 13, which indicated her cognition was intact. Resident #3 required substantial/maximal assistance with showering/bathing. Record review of Resident #3's care plan with a target date of 07/20/2026 indicated she required assistance by staff with showering. Record review of Resident #3's Shower Sheets dated 05/01/2026-06/17/2026 indicated she had a bath on 05/01/2026, 05/06/2026, 05/29/2026 and she refused a shower on 05/11/2026. There were no other shower sheets provided for the month of May 2026 and no shower sheets provided for the month of June 2026. Record review of Resident #3's Documentation Survey Report for the Month of May 2026 indicated bathing on Monday, Wednesday, and Friday on the 6 AM-6 PM shift. Resident #3 did not receive a bath on 05/08/2026, 05/15/2026, 05/18/2026, 05/22/2026, and 05/27/2026. Record review of Resident #3's Documentation Survey Report for the Month of June 2026 indicated bathing on Monday, Wednesday, and Friday on the 6 AM-6 PM shift. Resident #3 did not receive a bath on 06/03/2026, 06/05/2026, 06/10/2026, and 06/15/2026. During an observation and interview on 06/16/2026 at 2:02 PM, Resident #3 said she was not receiving her baths as scheduled. She said she was supposed to get them on Monday, Wednesday, and Friday, but she had not received one since last Friday (06/12/2026). She said she should have received a bath yesterday (06/15/2026), but she did not. She said when she asked the staff about her baths they told her they do not have time and they were short staffed. Resident #3's hair appeared oily and disheveled. During an interview on 06/16/2026 at 6:26 PM, CNA B said Resident #3 reported to her she had not been getting her showers as scheduled. CNA B said if she had time, she would give her a shower but sometimes she did not have time to give it to her. CNA B said being short staffed made it hard to give the residents showers. CNA B said if she missed a shower she tried to give it to them the next day. CNA B said she reported to the charge nurse and to the ADON when she did not have time to give showers. CNA B said it was important for the residents to get their showers for their hygiene, and they could get sick if they were not clean. During an interview on 06/17/2026 at 5:14 PM, CNA C said Resident #3 reported to her that she was not getting her showers, and she reported it to the charge nurses. CNA C said when she provided care to Resident #3, she gave her showers and had not missed giving any showers. CNA C said it was important for the residents to receive their showers so they would be clean and feel good. During an interview on 06/17/2026 at 5:26 PM, LVN A said she was aware residents were not receiving showers/baths as scheduled. LVN A said when they did not have enough staff, they did not get all the showers completed. LVN A said she reported this to the ADON. LVN A said it was important for the residents to receive their showers/baths for their hygiene and to prevent infections. During an interview on 06/17/2026 at 5:52 PM, the ADON said to her knowledge the showers were being done. The ADON said the Treatment Nurse was responsible for monitoring to ensure the residents were getting their baths. The ADON said if it was reported in the morning meeting that a resident did not receive their bath the CNA was notified for them to give a bath the same day. The ADON said if showers were not done it could affect (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents' mood and it could affect their skin. During an interview on 06/18/2026 at 8:50 AM, the Treatment Nurse said she used the shower sheets to monitor to ensure the showers were completed. The Treatment Nurse said some of the staff were not completing the shower sheets, but they also documented bathing in the resident's clinical record. The Treatment Nurse said she was not aware of any residents not receiving their showers/baths. The Treatment Nurse said it was important for the residents to get their baths for cleanliness, infection control, and the health of their skin. During an interview on 06/18/2026 at 1:47 PM, the Regional [NAME] President said the residents should receive their showers/bathing according to their schedule, and if they requested a shower outside of their schedule the staff should accommodate for them. He said the Interim DCO was responsible for ensuring the residents received their baths. He said it was important for hygiene issues. During an interview on 06/18/2026 at 3:11 PM, the Director of Resident Support Services said the Interim DCO was not available for interview. Record review of the facility's policy, Shower/Tub Bath, revised 10/2010, indicated, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The following information should be recorded on the resident's ADL record and/or in the resident's medical record: The date and time the shower/tub bath was performed. The name and title of the individual(s) who assisted the resident with the shoer/tub bath.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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 observation, interview, and record review the facility failed to ensure based on the comprehensive assessment of a resident, the 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 3 (Resident #1) residents reviewed for quality of care. The facility failed to ensure a skin assessment was conducted on Resident #1 after CNA B observed a new open wound on his front perineal area on 06/17/2026. This failure could place residents at risk for not receiving appropriate care and treatment, a decreased quality of life, and worsening pressure ulcers. Findings included: Record review of Resident #1's face sheet dated 06/18/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of the arms, trunk, and legs resulting from damage to the brain and/or spinal cord), neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for toileting, had an indwelling catheter, was always incontinent of bowel, and had unhealed pressure ulcers. Resident #1 was at risk of developing pressure ulcers/injuries. Record review of Resident #1's Order Summary Report dated 06/17/2026 did not indicate any orders for his front perineal area. Record review of Resident #1's Skin Assessment completed by the Treatment Nurse dated 06/16/2026 did not indicate he had a wound to his front perineal area. Record review of Resident #1's Skin Assessment completed by the Treatment Nurse dated 06/18/2026 indicated he had a wound to his posterior left perineal area that measured 3 cm (length), 1.6 cm (width), 0.1 cm (depth). The wound was open and pink, red with light amount of pink exudate (drainage). The current wound treatment indicated cleanse wound with Theraworx (wound cleanser), pat dry, apply collagen powder (powder used to promote wound healing), and cover with border gauze daily and as needed. The Skin Assessment indicated the wound was a new wound. Record review of Resident #1's Progress Notes dated 06/01/2026-06/18/2026 indicated: 06/18/2026 at 9:41 AM, spoke to the NP about new open area to posterior left upper thigh new order given to cleanse area with Theraworx pat dry apply collagen, and cover with border gauze daily completed by the Treatment Nurse. There were no other notes regarding Resident #1's wound to his front perineal area. Record review of Resident #1's care plan with a target date of 07/20/2026 indicated he had a pressure injury to his right hip to monitor/document/report as needed any changes in skin status. Resident #1's care plan indicated to check all his body for breaks in his skin and treat promptly as ordered by the doctor and to assess his skin weekly and record findings in his clinical record. Resident #1's care plan did not indicate any wounds to his front perineal area. During an interview and observation of incontinent care with CNA B on 06/17/2026 starting at 9:34 AM, surveyor observed an open wound on Resident #1's front perineal area. The wound was located in his left lower groin area to the side of his scrotal sac. The wound was open, appeared light pink and had edges, it was approximately 1.5 inch long and 1 inch wide. CNA B said she had not seen this wound before. Resident #1 said he was not aware of having a wound in that area, but it felt sore. CNA B said she would notify the nurse. During an interview on 06/17/2026 at 4:58 PM, CNA B said she was not aware Resident #1 had the open area on the left side of his front perineal area, but she reported it to the Treatment Nurse when she finished providing care to him (06/17/2026). CNA B said it was important for wounds to be reported and assessed promptly so they did not worsen and for them to be treated quicker. During an interview on 06/18/2026 at 8:56 AM, the Treatment Nurse said she conducted a skin sweep earlier in the morning (06/18/2026) to check the residents' skin and identified a new wound on Resident #1 in (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n Gilmer, TX 75644	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his front perineal area and was awaiting new orders from the NP. The Treatment Nurse said CNA B did not report to her Resident #1 had a wound on his front perineal area. The Treatment Nurse said if a new wound was observed by the CNAs, they should report it to the charge nurses or if she was in the building they could report it to her. The Treatment Nurse said when a new wound was reported she conducted a skin assessment and notified the doctor for new orders. She said when she conducted his skin assessment on 06/16/2026 she did not notice he had an open area to his front perineal area. The Treatment Nurse said the open wound on Resident #1's front perineal area likely had been there for days because it was not something that happened overnight. She said it was probably caused from friction when they were applying his brief. The Treatment Nurse said it was important for new wounds to be reported and assessed promptly so they did not worsen. During an interview on 06/18/2026 at 10:55 AM, LVN A said she was not aware Resident #1 had an open area to his front perineal area. LVN A said there was a lack of communication and the CNAs should be reporting to her any new findings on the residents' skin. LVN A said she did not conduct skin assessments on him that the Treatment Nurse did, but if the CNA noticed a new area the CNA should notify her. LVN A said the CNAs should report any new wounds to the charge nurses and the charge nurses would assess the area, notify the Treatment Nurse, and doctor for orders. LVN A said it was important for new wounds to be identified and assessed to ensure the proper treatment was in place. LVN A said not promptly addressing new wounds could result in the wound worsening. During an interview on 06/18/2026 at 1:44 PM, the Regional [NAME] President said he expected the CNAs to notify the Treatment Nurse of new wounds. He said he expected the Treatment Nurse to notify the family and doctor of new wounds and get an order for treatment. The Regional [NAME] President said he was not clinical and he could not determine what could happen if wounds were not assessed and treated promptly. During an interview on 06/18/2026 at 3:11 PM, the Director of Resident Support Services said the Interim DCO was not available for interview. Record review of the facility's policy titled, Skin Management: Prevention and Treatment of Wounds, revised 10/06/2022, indicated, The purpose of this procedure is for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds. Resident Care Providers will complete a Stop and Watch form in Point of Care from the resident's chart, which alerts on the nurse's clinical dashboard. A licensed nurse will address the alert after completing an assessment of the resident's skin area and complete the e-INTERACT Change in Condition form for newly identified wounds. A licensed nurse will notify resident's physician, responsible party, and hospice nurse if on services, with new onset of wounds or deterioration in wound status. A licensed nurse will obtain orders from physician for new skin wounds and transcribe onto resident's treatment record for follow up.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents. The facility failed to ensure CNA B and CNA D performed a proper transfer with the mechanical lift when they caused Resident #1's wheelchair to tip backward and failed to guide the bar of the mechanical lift so it would not make contact with Resident #1's head on 06/17/2026. This failure could place residents at an increased risk of falls and injuries. Findings included: Record review of Resident #1's face sheet dated 06/18/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of the arms, trunk, and legs resulting from damage to the brain and/or spinal cord), neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for toileting, had an indwelling catheter, was always incontinent of bowel, and had unhealed pressure ulcers Record review of Resident #1's Order Summary Report dated 06/17/2026 did not indicate the use of a mechanical lift for transfers. Record review of Resident #1's care plan with a target date of 07/20/2026 indicated he required assistance with his ADLs related to quadriplegia and required assistance by staff for transfers. The care plan did not specifically address the use of a mechanical lift. During an observation on 06/17/2026 at 10:07 AM, CNA B and CNA D transferred Resident #1 from his bed to his wheelchair with the use of a mechanical lift. CNA B lifted Resident #1 with the mechanical lift. Resident #1's wheelchair was positioned sideways to the mechanical lift rather than directly facing the lift. CNA B rolled the mechanical lift towards the sideways positioned wheelchair and opened the legs to where one leg of the lift was positioned towards the back wheels, and the other leg was positioned in front of the front wheels. CNA B and CNA D rotated Resident #1 to lower him into the wheelchair. As they were lowering Resident #1 into the wheelchair the leg of the mechanical lift got stuck on the front wheels, and Resident #1's wheelchair tipped slightly back. CNA D was attempting to hold it with her body weight to keep it from falling back, and she told CNA B the wheelchair was stuck. They stopped and were attempting to reposition the wheelchair to dislodge the bottom of the lift leg from the front wheels. The bar of the mechanical lift went towards Resident #1's head and he hollered Oh, oh, and CNA D was able to grab the bar before it struck his head. The bar brushed Resident #1's head but did not strike him directly. CNA B and CNA D dislodged the lift leg and prevented the wheelchair from tipping back and completed the transfer. During an interview on 06/17/2026 at 4:58 PM, CNA B said when using the mechanical lift for transfers they should pay attention to the bar of the mechanical lift and hold it away from the resident's head. CNA B said some of the wheelchairs required using the mechanical lift from the side. CNA B said when they transferred Resident #1 with the mechanical lift, they should have placed his wheelchair facing the mechanical lift. CNA B said during the transfer Resident #1's wheelchair started tipping back because it got stuck on the leg of the lift, and this could have caused Resident #1 to fall and get injured. CNA B said she was not paying attention to the bar and did not notice it was going to hit Resident #1's head. CNA B said she felt like she did not have the appropriate training when she started at the facility. CNA B said a competency check was completed, but she felt like she required more hands-on training. During an interview on 06/17/2026 at 10:51 AM, CNA D said when transferring Resident #1 they should have changed the direction the wheelchair was (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n Gilmer, TX 75644	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facing the mechanical lift to prevent his wheelchair from tipping back. CNA D said she was concentrating on ensuring Resident #1's arm and shoulder did not catch on the mechanical lift, so she was not paying attention to the bar of the mechanical lift. She said they should have guided the bar during the transfer to prevent injuries to Resident #1's head. CNA D said there was a big miscommunication between CNA B and herself during the transfer. She said the improper transfer could have resulted in Resident #1 falling or getting hurt. During an interview on 06/17/2026 at 6:11 PM, the ADON said during a transfer with a mechanical lift the staff should drive the mechanical lift towards the wheelchair so the legs of the lift were on each side of the wheelchair. She said the front of the mechanical lift should face the front of the wheelchair. The ADON said if it was not positioned in this manner it could result in the wheelchair tipping over and the residents falling and injuring themselves. The ADON said the staff member who was behind the resident during the transfer should guide the bar of the lift and hold it out of the way to prevent it from hitting the resident. She said competency checks were conducted when the CNAs were hired, and after that she conducted random check-ins to ensure they were transferring the residents properly. During an interview on 06/18/2026 at 1:37 PM, the Regional [NAME] President said he expected the staff to follow the guidelines while performing a transfer by mechanical lift to ensure the safety of the residents. He said the Interim DCO was responsible for ensuring the staff had knowledge on safe transfer practices. During an interview on 06/18/2026 at 3:11 PM, the Director of Resident Support Services said the Interim DCO was not available for interview. Record review of the facility's policy titled, Safe Lifting and Movement of Residents, revised July 2017, indicated, In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents.12. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which: a. Involves employees in identifying problem areas and implementing workplace safety and injury-prevention strategies.Provides training on safety, ergonomics and proper use of equipment.		

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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 was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #1) reviewed for indwelling urinary catheters. The facility failed to ensure Resident #1's urinary catheter was secured to his leg on 06/17/2026. This failure could place residents at risk for damage to the bladder, penis, or urethra (a hollow tube that lets urine leave your body), dislodging of the catheter, and urinary tract infections. Findings included: Record review of Resident #1's face sheet dated 06/18/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of the arms, trunk, and legs resulting from damage to the brain and/or spinal cord), neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for toileting and had an indwelling catheter. Record review of Resident #1's Order Summary Report dated 06/17/2026 did not indicate orders for Resident #1's urinary catheter. Record review of Resident #1's care plan with a target date of 07/20/2026 did not address securing his foley catheter. During an observation and interview on 06/17/2026 at 9:17 AM, Resident #1's foley catheter was not secured to his leg. Resident #1 said he was not aware it was not secured to his leg. During an interview on 06/17/2026 at 4:58 PM, CNA B said she did not know for how long Resident #1's foley catheter had not been secured to his leg. CNA B said she notified the nurse after providing care to him that he needed his foley catheter secured to his leg. CNA B said it was important for the foley catheters to be secured properly to prevent them from getting pulled and prevent injuries to the resident's penis. During an interview on 06/17/2026 at 6:14 PM, the ADON said if the CNA noticed a residents foley catheter was not secured they should let the nurse know. The ADON said she did not know why Resident #1 did not have orders for his foley catheter. The ADON said the MDS Coordinator was responsible for the orders for the foley catheters and for ensuring the staff were properly securing them. The ADON said if foley catheters were not properly secured they could pull and result in an injury. During an interview on 06/18/2026 at 10:55 AM, LVN A said she was not notified Resident #1 did not have his foley catheter secured. LVN A said the CNAs were responsible for ensuring it remained secured and that the CNAs should report to the charge nurses when they noticed the foley catheters were not secured. She said she was not aware Resident #1 did not have orders for his foley catheter. She said the ADON and DON reviewed the residents' orders to ensure they had the necessary orders in place. She said foley catheters needed to be secured to ensure they did not pull and to ensure the foley catheter did not irritate the penis. During an interview on 06/18/2026 at 2:57 PM, the MDS Coordinator said she was not responsible for the foley catheter orders or for ensuring the staff were properly securing them. The MDS Coordinator said the charge nurses were responsible for ensuring the residents had orders for their foley catheters and the charge nurses and CNAs should be ensuring the foley catheters were properly secured. The MDS Coordinator said securing the foley catheter kept it from getting pulled and causing trauma. She said if it was not secured it could cause infections. During an interview on 06/18/2026 at 1:42 PM, the Regional [NAME] President said foley catheters should be strapped to the residents' legs. He said the Interim DCO was responsible for ensuring this happened. He said he did not know what could happen if it was not strapped because he was not clinical. During an interview on 06/18/2026 at 3:11 PM, the Director of Resident Support Services said the Interim DCO was not available for interview. Record review of (continued on next page)		

Department of Health & Human Services
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Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy, Catheters-Insertion and Care: Indwelling, Straight, Supra-Pubic, and External, effective 04/2021, indicated, It is the policy of this community that the resident with a urinary catheter will be provided services in a safe and appropriate manner to minimize the risks of urinary tract complications. Physician order is required for all catheters. Order should contain the following: Type of catheter, size of catheter and size of bulb, Frequency to change catheter, Frequency to change drainage bag. Attach catheter strap to leg to assist in securing tubing.		

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 1 of 1 facility reviewed for care and services. The facility failed to provide sufficient CNAs according to the facility assessment on 05/18/2026, 05/21/2026, 05/22/2026, 05/23/2026, 05/24/2026, 05/30/2026, 05/31/2026, 06/06/2026, 06/09/2026, 06/13/2026, 06/14/2026, 06/15/2026 This failure placed residents at risk of inadequate supervision, an unsafe environment, falls, serious harm and injury, exacerbations of disease processes, and a decreased quality of life. Findings included: During an interview on 06/16/2026 at 12:30 PM, Resident #6 said it took the staff a long time to answer the call lights, and sometimes he had to call the nurses' station on the phone to have them provide incontinent care. Resident #6 said in the past he had waited for his call light to be answered or to be provided incontinent care from one and a half hours to five hours. During an interview on 06/16/2026 at 1:46 PM, Resident #5 said the staff took a long time to answer the call light and she had to wait a long time to be changed. Resident #5 was unable to provide exact times. During an observation and interview on 06/16/2026 at 2:02 PM, Resident #3 said she was not receiving her baths as scheduled. Resident #3's hair appeared oily and disheveled. She said she should have received a bath yesterday (06/15/2026), but she did not. She said when she asks the staff about her baths they tell her they do not have time and they are short staffed. Resident #3 said it took the staff a long time for them to respond to the call light. During an interview on 06/16/2026 at 5:03 PM, the Ombudsman said the facility had a lot of staff who left over the past 2 weeks. The Ombudsman said the residents complained to her about the lack of staff and call lights not being answered. During a confidential interview Anonymous Person #1 said they often did not have enough staff to fulfill all the residents' needs. They said when there was not enough staff the residents did not get their showers and they did not even have time to pass out water to the residents. Anonymous Person #1 said the residents reported to her not getting showers, not getting changed and the call lights not getting answered in a timely manner. They said when they were short staffed nurse management did not step in and help them. They said the residents had to wait for extended amounts of time to get changed. They said they reported it to the previous DON and the ADON. They said this placed the residents at risk for worsening wounds, dehydration, and UTIs. During a confidential interview Anonymous Person #2 said the residents reported to her they were not getting changed and the call lights were not answered in a timely manner. They said there were times when they were short-staffed and could not pass out ice and water and they missed giving baths. They said staff call off and they were not replaced. They said they reported not having enough staff to fulfill the residents' needs to the ADON and previous DON. They said not having enough staff placed the residents at risk of getting sick, injuries, dehydration, and more skin problems. During a confidential interview Anonymous Person #3 said sometimes they were short and did not have enough staff. Anonymous Person #3 said when they were short, they were not able to accomplish all their tasks and the residents did not get their showers, they were unable to change people in a timely manner, and call lights were not answered timely. They said residents have reported to him not being changed during the night and not being helped out of bed because of the lack of staff. They said they reported these things to the charge nurse. They said not providing required care to the residents placed them at risk for neglect, UTIs, and skin breakdown. During a confidential interview Anonymous Person #4 said they did not have enough staff to change the residents in a timely manner and give them their showers. They said they reported this to the ADON and charge nurse. They said not providing care to the residents could be considered neglect. They said due to not having enough staff the residents could feel they were stressed or they could get talked to wrong, the residents may not want to ask for (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	help because they knew they were short, or they could get wounds. During a confidential interview Anonymous Person #5 said the residents reported to her not getting changed and the call lights not getting answered in a timely manner, and they noticed it had been when they were short staffed. They said they reported it to the ADON. They said not having enough staff could affect the residents' care and they could be neglected. During a confidential interview Anonymous Person #6 said sometimes they did not have enough staff, and she missed some of the showers. They said the residents reported to them not getting changed due to being short staffed. They said they reported this to the charge nurse. They said not having enough staff could cause the residents emotional damage and they could be more prone to getting sick more often. During a confidential interview Anonymous Person #7 said sometimes they did not have enough CNAs, and it was a struggle. They said a lot of the residents required 2 staff to assist them with transfers, so it made it difficult to assist them in a timely manner. They said the residents reported to them the call lights not being answered. They said sometimes the showers were missed due to not having time to complete them. Anonymous Person #7 said if they did not have enough staff the residents could get wounds, fall, and life-threatening things could happen to them. During an interview on 06/17/2026 at 5:52 PM, the ADON said the staff had reported to her they were not able to accomplish all of their tasks, and she had discussed time management with them because they were taking too many breaks. The ADON said the staff reported to her that they were short-handed. She said the facility had a staffing ratio she followed when she did the scheduling, and the staffing ratio was 5 CNAs for the day shift (6 AM- 6 PM) and 3 CNAs for the night shift (6 PM- 6 AM). The ADON said if there were any call ins she found somebody to fill in or she worked on the floor. During an interview on 06/18/2026 at 1:48 PM, the Regional [NAME] President said staffing was volatile and as far as being shorthanded they might have to work harder that the day before, but his expectations were for the residents to be taken care of. He said to his knowledge the facility was adequately staffed. He said if there was a call in there was an on-call phone and the individual with the phone was responsible for finding coverage or working. He said they should have 5 CNAs on the day shift and 4 CNAs on the night shift. He said if they were not adequately staffed he assumed the responsibilities would not be completed timely. During an interview on 06/18/2026 at 3:11 PM, the Director of Resident Support Services said the Interim DCO was not available for interview. Record review of the Facility assessment dated [DATE] indicated, 5 CNAs for the 6 AM- 6 PM shift and 3 CNAs for the 6 PM- 6 AM shift. Record review of the timecards dated 05/18/2026- 4 CNAs05/21/2026- 3CNAs05/22/2026- 4 CNAs05/23/2026- 4 CNAs05/24/2026- 4 CNAs05/30/2026- 4 CNAs05/31/2026- 3 CNAs06/06/2026- 4 CNAs06/09/2026- 3 CNAs06/13/2026- 3 CNAs06/14/2026- 2 CNAs06/15/2026- 3 CNAs Record review of the timecards dated 05/18/2026-06/15/2026 indicated the facility did not have 3 CNAs for the 6 PM- 6 AM shift on: 05/21/2026- 2 CNAs05/23/2026- 2 CNAs06/13/2026- 2 CNAs06/14/2026- 2 CNAs06/15/2026- 2 CNAs Record review of the facility's policy, Staffing, revised 10/2017, indicated, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.		

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Form Approved OMB
No. 0938-0391

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 06/18/2026
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 2 medication carts (100/300/400 Hall Medication Cart and the 200 Hall Medication Cart) reviewed for drugs and biologicals. The facility failed to ensure LVN O secured the 100/300/400 Hall Medication Cart and the 200 Hall Medication Cart, when they were not in use on 06/17/2026. This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: During an observation on 06/17/2026 starting at 6:34 PM, the 200 Hall Medication Cart was observed unlocked and unattended stationed against the wall leading to the kitchen. LVN O was observed standing in front of the 100/300/400 Hall Medication Cart with her back to the 200 Hall Medication Cart on her computer. LVN O walked down the hall and went into a room. LVN O left the 100/300/400 Hall Medication Cart unlocked. Staff and residents were observed around the unlocked medication carts. LVN O returned to the nurses' station and both Medication Carts remained unlocked. Surveyor intervened and LVN O locked the medication carts. LVN O said the medication carts should be locked whenever she walked away from them. She said it was a mistake she left them unlocked because she was working between the two medication carts. She said they should be locked to ensure nobody stole the medications or nobody walked away with any of the medications or the residents did not get into the medication. During an interview on 06/18/2026 at 1:46 PM, the Regional [NAME] President said medication carts should be locked at all times, unless they were in use. The Regional [NAME] President said the Interim DON was responsible for ensuring the staff were locking the medication carts. He said an unlocked medication cart placed the residents at risk for potential exposure to medications. During an interview on 06/18/2026 at 3:06 PM, the ADON said medication carts should be locked anytime it was not within the staff's sight and when they walked away from it. The ADON said the nurse responsible for the medication cart should ensure it was locked when not in use. The ADON said if the medication cart was left unlocked the residents could get the medications or anybody could take medications from it. Record review of the facility's policy, Storage of Medications, revised 08/2020, indicated, Medications and biologicals are stored safely, securely, and properly. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents (Resident #1, Resident #2, and Resident #4) reviewed for infection control. The facility failed to ensure CNA B and CNA D followed enhanced barrier precautions when providing care to Resident #1 on 06/16/2026. The facility failed to ensure the ADON and the Treatment Nurse provided proper wound care to Resident #1 on 06/16/2026. The facility failed to ensure Resident #2 had proper signage to indicate he required the use of contact precautions. The facility failed to ensure RN F followed contact precautions when providing wound care to Resident #2 on 06/13/2026. The facility failed to ensure LVN N followed enhanced barrier precautions when providing care to Resident #4 on 06/16/2026. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: 1. Record review of Resident #1's face sheet dated 06/18/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of the arms, trunk, and legs resulting from damage to the brain and/or spinal cord), neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for toileting, had an indwelling catheter, was always incontinent of bowel, and had unhealed pressure ulcers. Record review of Resident #1's Order Summary Report dated 06/17/2026 indicated: Right hip, cleanse with Theraworx (wound cleanser), pat dry, pack with Dakin's (wound cleaning solution) soaked gauze, and cover with dry dressing with an order date of 06/16/2026. Sacral (lower back/buttocks area) wound, cleanse with Theraworx, apply honey and calcium alginate to wound bed and cover with dry dressing with an order date of 06/09/2026. Left lateral (side) foot, cleanse with Theraworx, apply xeroform and calcium alginate and cover with dressing with an order date of 06/09/2026. There were no orders for EBP. Record review of Resident #1's care plan with a target date of 07/20/2026 indicated he was on EBP due to a chronic wound or skin opening requiring dressing changes and an indwelling catheter. Resident #1's care plan indicated staff would maintain EBP during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or toileting, and when they performed any type of device care such as but not limited to the following urinary catheter care and wound care. Resident #1's care plan indicated he had pressure wounds to perform treatments per the doctor's orders. He required assistance with his ADLs related to quadriplegia, and he required assistance by staff for toileting and transfers. During an observation on 06/17/2026 at 9:17 AM, CNA B and CNA D entered Resident #1's room to provide incontinent care. CNA D grabbed Resident #1's catheter bag and tubing without any gloves or a gown on to see if it needed to be emptied. CNA B put on gloves and emptied Resident #1's foley catheter bag. CNA B did not wear a gown. CNA B had the same gloves on that she emptied the foley catheter bag and CNA D put on some gloves, and they took off Resident #1's blanket to change his brief. CNA B and CNA D still did not wear a gown. They realized the wound dressing on Resident #1's right hip needed to be changed and stopped to go get the nurse. During an observation on 06/17/2026 starting at 9:34 AM, CNA B entered Resident #1's room to provide incontinent care. CNA B unfastened Resident #1's brief and cleansed his front perineal area. CNA B turned Resident #1 on his side and wiped Resident #1's buttocks multiple times with the same wipe, grabbed another wipe and repeated the same action. The stool from Resident #1's dirty brief got on the draw sheet (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(white folded blanket often used to reposition the resident in the bed) underneath him. CNA B removed the dirty brief and took off her gloves. CNA B did not perform hand hygiene after she removed her gloves. Resident #1 remained on his side for wound care to his buttocks. The ADON entered the room and put on gloves and a gown to provide wound care. The ADON removed the dirty dressing to Resident #1's buttocks, removed and discarded her gloves, and applied new ones. The ADON did not perform hand hygiene after glove removal. Resident #1's open wound was directly on the dirty draw sheet. The ADON cleansed Resident #1's wound, changed gloves, and applied new gloves. The ADON did not perform hand hygiene after glove removal. The ADON applied the dressing, removed her gloves, applied new ones. The ADON did not perform hand hygiene after glove removal. The ADON removed the dirty dressing to Resident #1's right hip, cleaned the wound, removed her gloves, and applied new gloves. The ADON did not remove her gloves after removing the dirty dressing and did not perform hand hygiene after removing her gloves. The ADON completed the wound care, removed her gloves, and performed hand hygiene. The Treatment Nurse entered the room to provide wound care to Resident #1's left foot and put on a gown and gloves. The Treatment Nurse removed the dirty dressing, changed gloves, and grabbed gauze to cleanse the wound. The Treatment Nurse wiped multiple times back and forth when cleaning the wound, set the gauze on the bed to reposition Resident #1's foot, picked the gauze back up and wiped across the wound multiple times with the same gauze. The Treatment Nurse completed the wound treatment, removed her gloves and performed hand hygiene. During an interview on 06/17/2026 at 10:51 AM, CNA D said residents with foley catheters and wounds required EBP when changing them. CNA D said she should have worn a gown and gloves when she checked Resident #1's foley catheter bag. CNA D said not wearing a gown and gloves could result in the spread of bacteria. During an interview on 06/17/2026 at 4:58 PM, CNA B said Resident #1 required EBP and she should have put on a gown and gloves when she provided direct care to him. CNA B said hand hygiene should be performed before she went into the resident's room, before she put gloves on, and after she provided care. CNA B said during incontinent care she should wipe once and discard the wipe and get a new one to prevent UTIs. CNA B said she should have removed the dirty draw sheet when she finished cleaning up Resident #1. She said leaving the dirty draw sheet could result in a wound infection. CNA B said EBP were required to prevent the residents from getting more infected and to keep them from getting what the residents had. 2. Record review of Resident #2's face sheet dated 06/17/2026, indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia mild without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without any behaviors or disturbances), atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow), and methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere (a type of bacteria that causes skin infections and is resistant to many antibiotics). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated he was rarely/never understood by others and rarely/never understood others. The MDS assessment indicated Resident #2 had a short-term and long-term memory problem. The MDS assessment indicated Resident #2 was dependent on staff for all ADLs. Resident #2 had a total of 2 venous and arterial ulcers present. Record review of Resident #2's Order Summary Report dated 06/17/2026 indicated: Right first metatarsal, cleanse with Theraworx, apply gentamycin 0.1% (antibiotic) cream to wound bed and secure with dry dressing three times a day for wound healing for 14 days with an order date of 06/11/2026. There were no orders for contact precautions. Record review of Resident #2's care plan with a target date of 08/03/2026 indicated he was on EBP due to a chronic wound or skin opening that required a dressing change. Resident #2's care plan indicated staff would maintain EBP while performing wound care. During an observation of a video dated 06/13/2026 timed 11:52 AM, RN F entered Resident #2's room and provided wound care to his right foot. RN F failed to put on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a gown. During an observation of a video dated 06/13/2026 timed 3:31 PM, RN F entered Resident #2's room and provided wound care to his right foot. RN F failed to put on a gown. During an observation on 06/16/2026 at 12:55 PM, there was a sign for EBP outside of Resident #2's room on the doorframe. There was no sign to indicate he required contact precautions. During an observation on 06/17/2026 at 8:59 AM, Resident #2 had a sign on his doorframe that indicated he required EBP. There was no sign to indicate he required contact precautions. During an interview on 06/17/2026 at 4:16 PM, RN F said she provided Resident #2's wound care treatments on 06/13/2026. RN F said she did not wear a gown when providing Resident #2's wound care because she did not realize he required contact precautions. RN F said Resident #2 did not have a sign on his door that indicated he was on contact precautions. RN F said any of the nurses who knew he required contact precautions could have placed a sign on Resident #2's door to alert staff and visitors to put on the appropriate PPE. RN F said she should have applied a gown and gloves when providing care to Resident #2. RN F said not following the proper PPE precautions during wound care and not posting a sign with the required precautions could result in the spread of infection. 3. Record review of Resident #4's MDS assessment dated [DATE] indicated she admitted to the facility on [DATE]. Resident #4 had diagnoses which included spinal stenosis in the lumbar region with neurogenic claudication (narrowing of the spinal canal that compresses nerve roots and causes weakness and pain, numbness, or tingling in one or both legs) and infection following a procedure deep incisional surgical site (infection to an incision (cut) made for a surgical procedure). Resident #4 understood others and was understood by others. Resident #4 had a BIMS score of 14, which indicated her cognition was intact. Resident #4 required substantial/maximal assistance with toileting and bathing and required partial/moderate assistance with personal hygiene. Resident #4 had a surgical wound and received wound care. Record review of Resident #4's Order Summary Report dated 06/16/2026 indicated: Lower back wound cleanse with TheraWorx apply foam to wound bed cover with drape and apply wound vac (vacuum-assisted closure; machine used to apply suction to the wound for wound healing) at 125 mmhg as needed for dislodgement of drape or foam with an order date of 05/30/2026. There were no orders for EBP. Record review of Resident #4's care plan with a target date of 08/20/2026 did not address the use of EBP. During an observation on 06/16/2026 at 1:28 PM, LVN N entered Resident #4's room to reconnect Resident #4's wound vac. LVN N did not put on a gown or gloves. LVN N grabbed Resident #4's wound vac and the tube on the wound vac with her ungloved hands and wiped off the tip of the wound vac tubing with an alcohol swab to reconnect it. LVN N grabbed Resident #4's linens, uncovered her, and attempted to locate the other end of the tube on Resident #4's back with her ungloved hands. LVN N was unable to reach the other end of the tube without turning Resident #4 on her side. LVN N said she was going to talk to the wound care doctor and exited the room. During an interview on 06/16/2026 at 5:59 PM, LVN N said EBP was required when a resident had wounds and a gown and gloves should be worn with any personal care, contact with clothes or any type of close contact, wound care, and incontinent care. LVN N said she forgot to put on a gown and gloves with Resident #4. LVN N said not following EBP could result in the spread of infection. During an interview on 06/17/2026 at 5:48 PM, the ADON said EBP should be followed when a resident had wounds, indwelling devices such as foley catheters. She said any time the staff provided care for those residents they should wear gloves and a gown. The ADON said when handling the foley catheter bag and tubing, the residents' linens, and a wound vac gloves and a gown should be worn. The ADON said hand hygiene should be performed before and after providing care and after glove removal. The ADON said when providing incontinent care, the staff should wipe once and discard the wipe and get a new one. She said proper incontinent care was required to prevent infections. The ADON said when she provided wound care to Resident #1, she should have rolled him over more for there to be less of a chance of the wound touching the bed. She said she should not have performed the wound care over the dirty draw sheet. The ADON said she forgot to perform hand hygiene in between glove changes, and she should have removed her gloves and applied new ones (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before the dressing was changed. The ADON said Resident #2 required the use of contact precautions because he had ESBL and MRSA in his wound. The ADON said she was responsible for putting up the signs to alert staff and visitors of the required precautions. The ADON said she had placed a sign on the door when they received the order to place him on contact precautions. The ADON said the residents should have orders for the precautions they required, and she did not know why they did not. The ADON said not performing adequate hand hygiene could result in a wound infection. The ADON said not following EBP could result in the spread of bacteria. The ADON said the Treatment Nurse, DON, and herself were responsible for ensuring the staff followed proper infection control practices. The ADON said she conducted random checks to see if the staff were following proper infection control practices. The ADON said not following contact precautions could result in the staff getting the bacteria on them and taking it to the residents. During an interview on 06/18/2026 at 1:32 PM, the Regional [NAME] President said the facility administrator had been terminated on 06/08/2026. He said he expected the staff to adhere to common perineal care practices, follow contact and enhanced barrier precautions, use sterile technique for wound care, and proper hand hygiene. He said the Interim DCO was responsible for monitoring the staff. He said he was not clinical and was not able to determine the risks and outcomes associated with not following proper infection control practices. During an interview on 06/18/2026 at 3:11 PM, the Director of Resident Support Services said the Interim DCO was not available for interview. Record review of the facility's policy titled, Perineal Care, effective 10/01/2021, indicated, To provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Wash and dry your hands thoroughly. Put on gloves. For a male resident: a. Use wipe and apply skin cleansing agent. b. Wash perineal area starting with urethra and working outward. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches.) (1) Retract foreskin of the uncircumcised male. (2) Cleanse the urethral area using a circular motion. (3) Continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same side of the disposable wipe, change the surface position of the disposable [NAME] and/or obtain a clean wipe to clean the urethra. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. Record review of the facility's policy titled, Transmission-Based Precautions for Infections, revised 10/24/2022, indicated, Contact- In addition to standard precautions, use Contact precautions (gown, gloves, mask or faceshield if splashing could occur) for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such and handling environmental surfaces or resident?care items. In some instances, residents colonized with these organisms may also require contact precautions for example, when a draining wound cannot be contained, when a resident exhibits noncompliant behavior with stool or other body fluids, or when a resident has very poor personal hygiene, etc. The above includes epidemiologically important organisms (Multidrug-resistant organisms) such as methicillin-resistant Staphylococcus aureus (MRSA). Hand hygiene- Hand hygiene, with alcohol-based hand rub or soap & water is recognized as the most important way to prevent the transmission of infection. All employees are required to perform hand hygiene prior to any resident contact, after unprotected contact with blood or other potentially infectious materials and after removing gloves. Hand hygiene with alcohol-based hand rub is preferred method, unless the hands are visibly soiled, before and after use of restroom, performing invasive procedures. 5. Transmission-based precaution signage for door of each resident room a. Signage should have Contact Nurse Prior to Entering b. All needed PPE should be listed on the signage. 8. Physician order is required to begin transmission-based precaution and to end transmission-based precaution. Record review of the facility's policy titled, Enhanced Barrier Precautions, effective 04/01/2024, indicated, Enhanced Barrier Precautions (EBP) are a CDC guidance to reduce the transmission of multi-drug resistant organisms (MDRO) in health care settings, including nursing homes. EBP require team members to wear a gown and gloves while performing high-contact care activities with residents who (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are infected or colonized with a targeted MDRO, or who have open wound or indwelling medical device. Determine if a resident has any wounds. chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds. Determine if any of the following indwelling medical devices are in use: urinary catheter. EBP will be implemented if any of the above wounds or invasive medical devices are present. 4. High contact resident care activities: Dressing Bathing/Showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting. Device care or use Wound care: any skin opening requiring a dressing.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside, for 1 of 1 facility reviewed for call lights. The facility failed to ensure the call light system was functioning properly. This failure could place residents at risk of injury, falls, and unmet needs. The findings included: During an interview on 06/16/2026 at 2:02 PM, Resident #3 said it was taking a long time for the staff to answer the call light. She said she had reported it to the nurses and they told her they were short. During an interview on 06/16/2026 at 7:22 PM, LVN P said some of the residents reported to her that the call lights were not being answered in a timely manner. She said they were having issues with the call lights because if 4 or more call lights went off on the 100 hall the call light system stopped working and all the call lights turned off. She said when they realized it had stopped working they would reset the board and it would start working again. LVN P said she had reported this to the previous DON and the ADON. LVN P said if the call lights were not functioning it could cause falls or the residents could have an emergency and not get the help they needed. During an interview on 06/17/2026 at 6:58 AM, LVN E said she had been working at the facility for 4 months. LVN E said the residents reported to her their call lights were not being answered in a timely manner. LVN E said if there were 5 or more call lights going off on the 100 hall the call lights would go off and stop working. She said if she was at the nurses' station and noticed the call light system turned off, she would reset it, but if she was not at the nurses' station, she would not know it stopped functioning. LVN E said the call light system had been doing this since she started working at the facility. She said she had reported it to the previous DON. LVN E said it was important for the call lights to properly function so the residents' needs could be met. During an observation and interview on 06/17/2026 at 8:27 AM, Maintenance Director L said the previous maintenance director left on 06/04/2026. He said he had not heard anything about the call system malfunctioning. Maintenance Director L and the Dietary Manager went down the 100 hall and activated multiple call lights. Surveyor stayed at the end of the hall by the nurses' station to observe. There were call lights on the other halls that were activated by residents. After multiple call lights were activated on the 100 hall. All of the call lights turned off and the call system board turned off. Maintenance Director L said he was not aware this was happening. He said he did not know how to print the maintenance log from their system, but he would try to see if he could figure it out (maintenance log was not provided upon exit of the facility). During an interview on 06/17/2026 at 8:28 AM, the Dietary Manager said she was aware the call light system was not functioning properly because one day over a month ago she was shocked that there were no call lights on. She said she started pushing buttons on the call light system's main board until it reset and the call lights came back on. The Dietary Manager said she reported it to the previous Maintenance Director, and it had not been fixed. The Dietary Manager said if the call lights were not functioning properly they could not provide the care that the residents' needed and if it were an emergency they would be delayed in finding out. During an interview on 06/17/2026 at 5:48 PM, the ADON said she had randomly been told by the residents that their call lights were not answered. The ADON said there was an issue down the 100 hall because there was a short in the circuit and if a couple of lights went off all the lights went completely off. The ADON said she had been aware of this for about two and a half months, and the previous maintenance director said he would contact the company that installed the call light system. The ADON said if the call light system was not functioning properly the residents could not receive the care they needed and they could not alert them when they needed something. During an interview on 06/18/2026 at 1:38 PM, the Regional [NAME] President said if the call light system was malfunctioning, he expected for it to be brought up in the morning meetings and for it to be placed in the maintenance log. He said he was not aware of the issue with the call light system that nobody had reported it to him. He said the call light (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system malfunctioning could impede the residents' ability to ask for help. Record review of the facility's policy, Maintenance Service, effective 02/01/2017, indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. A policy specific to the call light system was requested from the Director of Resident Support Services and not received upon exit of the facility.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free from pests in 3 of 3 halls reviewed for pest control.~ The facility did not maintain an effective pest control program to ensure the facility was free of flies.~ This failure could place residents at risk for an unsanitary environment and a decreased quality of life.~ Findings included: During a walk through the facility on 06/16/2026 starting at 11:41 AM, there were multiple flies observed on halls 100, 200, and 300. During an observation and interview on 06/17/2026 at 9:15 AM, there were multiple flies in Resident #1's room. He was observed shaking his head trying to get them away. He said this had been an ongoing issue but was not able to provide a timeframe. During an interview on 06/17/2026 at 6:16 PM, the ADON said the residents complained to her about the flies in the facility and in their rooms, and she had reported it to the previous maintenance director. She said she could not remember how long ago it had been. The ADON said it was important for their not to be any flies in the facility because it was unsanitary and it was a hazard to the residents. During an interview on 06/18/2026 at 10:55 AM, LVN A said several of the residents complained to her about the flies in the facility and their rooms and it had been at least a month since they had been complaining. LVN A said all the management staff had been notified and were aware that there were too many flies in the facility. LVN A said she had not logged it in the pest control book because she did not know she was supposed to. LVN A said it was important for the facility to be free of flies for the residents' comfort, for safety, and for general human living conditions. During an interview on 06/18/2026 at 11:08 AM, a representative with the facility's pest control company said they serviced the facility monthly, but their routine services did not cover flies and gnats. They said they were able to provide those services, but the facility had to contact them to request those services. They said the facility had not reached out to them to request services for flies and gnats. During an interview on 06/18/2026 at 11:32 AM, Maintenance Director L said he was helping at the facility until the facility hired a maintenance director. He said it had been a week since the previous maintenance director left. He said if there was an issue with flies and gnats the staff should report it to the maintenance director, and the maintenance director notified the pest control company and the pest control company would address the issue. He said the staff had not reported any issues with flies or gnats to him and he was not even aware of the last time the pest control company was at the facility. Maintenance Director L said it was important for there not to be flies and gnats in the facility for the residents' health. During an interview on 06/18/2026 at 1:43 PM, the Regional [NAME] President said if there were flies in the facility the staff should log it in the pest control book, and it was reviewed so that the specific issue was treated. He said the maintenance director was responsible for ensuring the facility was treated for flies. He said the flies could be annoying. Record review of the facility's pest control log dated from 10/06/2025-06/01/2026 did not indicate any issues with flies or services provided for flies. Record review of the facility's policy titled, Pest Control, revised May 2008, indicated, Our facility shall maintain an effective pest control program. This facility maintains an on-going pest control program to ensure that the building is kept free of insects.		