

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 12/04/2024
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n Gilmer, TX 75644	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good, nutrition, grooming and personal and oral hygiene for 1 of 12 residents (Residents #30) reviewed for activities of daily living.</p> <p>The facility failed to ensure Resident #30 received nail care.</p> <p>This failure could place residents at risk of not having their needs met which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health.</p> <p>Findings include:</p> <p>Record review of Resident #30's facility face sheet, dated 12/03/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #30 had a diagnosis which included atherosclerotic heart disease (buildup of plaque in the heart arteries).</p> <p>Record review of Resident #30's comprehensive care plan, dated 11/18/24, revealed Resident #30 had an ADL (activities of daily living) self-care performance deficit and required extensive assistance with most ADL's and staff to assist with personal hygiene.</p> <p>Record review of Resident #30's Quarterly MDS assessment, dated 10/01/24, revealed Resident #30 was rarely understood, and a BIMS was not completed. Further review revealed a staff assessment for mental status [SAMS] was completed and indicated moderately impaired cognitive skills for daily decision-making, required supervision and cueing and required moderate assistance with personal hygiene.</p> <p>During an observation on 12/02/24 at 9:47 AM revealed Resident # 30 was in the bed awake, and her fingernails were long, jagged, and had a thick black substance under them.</p> <p>During an observation and interview on 12/02/24 at 3:09 PM revealed Resident #30's fingernails were long, jagged, and had a dark thick substance under them. Resident #30 said it had been a while since her fingernails were cleaned and she might have dug in something .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/02/24 at 3:21 PM, CNA A said she had been employed at facility since July 2023 . She said she had been trained on providing ADL care and fingernails should be cleaned daily and trimmed as needed. She said she was assigned to Resident #30 the last few days she worked and had not noticed her fingernails were dirty and had not cleaned them . She said Resident #30 received her bath from hospice and thought they had been cleaning her fingernails. She said the treatment nurse also checked fingernails weekly and they should have been trimmed in the last week. She said dirty nails could cause infections and long nails could cause injuries.</p> <p>During an interview on 12/03/24 at 1:16 PM, the Treatment Nurse said she checked nails weekly with the skin assessment and she checked Resident #30's fingernails last week and they were fine. She said she didn't check Resident #30's skin and fingernails until late afternoon on 12/02/2024. She said in between her weekly checks the CNA's should be cleaning nails at least on bath days but checking them daily . She said nails left dirty and untrimmed could cause skin injuries and infections.</p> <p>During an interview on 12/04/24 at 11:16 AM, the DON said the aides were responsible for checking and cleaning nails daily and the treatment nurse was responsible for checking nails weekly and trimming them as needed. She said she expected that process to be followed to prevent the spread of infections or skin injuries. She said the facility did not have a specific policy on nail care or ADL care.</p> <p>During an interview on 12/04/24 at 11:58 AM, the Administrator said the aides and nurses were responsible for providing ADL care but everyone who was involved with the resident should be monitoring to ensure all services were provided. She said the treatment nurse was to check at least weekly that ADL care was provided. She said if ADL care was not provided the resident could have infections and dignity issues and she expected all residents got their needed ADL care. She said also there was no specific policy on ADL care and nail care.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</p> <p>Based on interview, Observation and record review the facility failed to ensure the facility had sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 6 residents (Resident #9) reviewed for staffing.</p> <p>The facility failed to have sufficient nursing staff to meet Resident #9's needs in a timely manner. Resident #9 said it took too long to have her call light answered, and to get ice and water on the days the facility was short staffed.</p> <p>This failure could place residents at risk for not having their physical, mental, and psychosocial well-being met.</p> <p>Findings include:</p> <p>Record review of Resident #9's face sheet, dated [DATE], indicated Resident #9 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #9 had diagnoses which included: hemiplegia and hemiparesis affecting left non-dominant side (weakness on one side of the body), epilepsy (seizures) and cognitive communication deficit (difficulty with communication).</p> <p>Record review of Resident #9's quarterly MDS assessment, dated [DATE], indicated a BIMS of 15, which indicated no cognitive impairment. Resident #9 had occasional urinary incontinence.</p> <p>Record review of Resident #9's care plan, dated [DATE], indicated Resident #9 was occasionally incontinent and at risk for skin breakdown with interventions which included: 1. Monitor for incontinence every 2 hours and as needed, change promptly, and apply protective skin barrier. 2. Monitor for signs and symptoms of skin breakdown and report abnormal findings to the physician and responsible party. 6. Monitor for signs and symptoms of infection and notify the physician and responsible party promptly.</p> <p>During an interview on [DATE] at 8:20 AM, Resident #9 said the facility did not have enough staff. She said there was only 1 nurse to care for all residents in the facility on each shift. She said the facility was sending home the CNA's early to cut down on the hours the CNAs were working. She said when the facility sent the CNA's home, they would have only 1 CNA to take care of all residents on the hall. She said when the facility sent staff home early, she would have to wait for an extended period for her call light to be answered. She said she understood the CNA was busy and there was only 1 nurse so she would just wait and not complain but thought it was not right for the facility to send staff home when they had residents to care for. She said she did not have any adverse issues due to having to wait for an extended period for care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on [DATE] at 8:37 AM, CNA F said he had worked at the facility for about 2 years. He said the ADON would notify a different CNA every week that needed to leave early due to the census being down. He said he had to leave at about 11:30 AM once a week to cut down on CNA hours. He said the facility had been doing this for the last couple of months and it had just gone back to normal last week. He said residents complained to him that it was taking a long time to get their call lights answered.</p> <p>During an interview on [DATE] at 8:45 AM, CNA G said the facility had been sending a CNA home early at about 11:30 AM for the last couple of weeks. She said they would work short on CNAs sometimes. She said there was 1 nurse for all the residents in the facility.</p> <p>During an interview on [DATE] at 8:57 AM, CNA B said they often worked short on CNA's. She said they worked short almost every day. She said the facility had been cutting CNA hours for a while and would send a CNA home early often.</p> <p>During a telephone interview on [DATE] at 5:30 PM, LVN M said the facility only scheduled one licensed nurse to work overnight. She said one nurse was not enough to safely care for all residents at the facility. She said the risks to residents are she would be unable to perform life-saving interventions such as CPR or Neurological checks for more than one resident in a multiple emergent need scenario. She said she expressed concerns to the facility Administrator, the DON and the ADON on multiple occasions and was told corporate would not allow staffing of two nurses overnight.</p> <p>During an interview on [DATE] at 6:00 PM, LVN N said she was the only nurse on her shift overnight. She said one nurse overnight for the facility was not enough to ensure resident safety. She said the risks for residents was one nurse would be unable to provide care if there were multiple falls or codes. She said she expressed concerns to the facility Administrator, the DON and the ADON and was told it's a corporate issue.</p> <p>During an interview on [DATE] at 10:22 AM, the DON said she had worked at the facility since [DATE]. She said she felt like there was sufficient staff in the building to meet the resident's needs. She said the night nurses made concerns known about their only being 1 nurse in the facility after hours. She said the nurse said if she needed to leave the facility for any reason, she would not be able to, due to only being 1 nurse at the facility. She said in her opinion she felt like 4 CNA's 1 CMA and 1 nurse was sufficient to provide care to 55 residents. She said she disagreed with the night nurse and said if the night nurse had 30 minutes to stand in her office and complain about not having enough time to get her work done, she should have spent that time working. The DON said she felt like it was safe for 1 nurse to care for 55 residents. She said if the nurses managed their time well, they should have enough time to get their work done. She said they didn't have the hustle and bustle on the night shift that happened on the day shift. She said she agreed they needed more help, but they could get the job done. The DON said some potential risk to the resident would be sometimes having to wait longer to receive care and not having needs met timelier.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on [DATE] at 11:01 AM, the Administrator said she had worked at the facility for about 5 months. She said their nurses were doing well with caring for the residents. She said there were administrative nurses who lived close to the facility to be able to help if needed. She said she was not aware the staffing per the facility assessment designated 3 nurses on the day shift, 2 evening shift and 1 on night shift. She said she was the one who completed the facility assessment and followed the template from corporate and she only added the numbers not thinking the medication aide was supposed to be a licensed nurse. She said they were sending CNA's home due to the census being down. The Administrator said they would have to evaluate the staffing as a team. She said she relied on the administrative nurses to judge if it was safe for 1 nurse to meet the needs of the resident census of 55. She said the risk to the residents by not staffing per the facility assessment was not meeting the resident's needs.</p> <p>During an interview on [DATE] at 11:01 AM, the ADON said she worked at the facility for about 3 years. She said 1 nurse could not effectively take care of 55 residents. She said she coordinated staffing for the building. She said corporate told her she had to cut staff due to the census being low. She said she was not aware of the staffing plan in the facility assessment and said she had never seen the facility assessment before. She said the potential harm to residents by not staffing per the facility assessment could be an increase in falls, and care could take longer.</p> <p>During an interview on [DATE] at 11:51 AM, the Corporate Consultant said she had been with the company for about 1 month. She said she would have to look at the acuity of the residents to determine if 1 nurse could effectively care for 55 residents. She was asked by the State Surveyor to check the acuity level and let the State Surveyor know if 1 nurse was sufficient. At the time of exit the Corporate Consultant had not made a determination.</p> <p>During an observation on [DATE], [DATE], and [DATE] the facility was observed to have 1 LVN on shift for 6: AM to 6:00 PM.</p> <p>Record review of the Daily Staffing sheets, dated [DATE] through [DATE], revealed:</p> <p>1 charge nurse scheduled for 12 hours 6am to 6pm daily, and 1 charge nurse schedule for 12 hours 6pm to 6am daily. 1 CNA was scheduled to leave early on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] leaving 4 CNA's to provide care to 55 residents.</p> <p>Record review of the daily staffing pattern, dated [DATE], revealed: Days: 1-RN and 1-LVN, Evenings: 0-RN and 0-LVN, Nights: 0-RN and 1-LVN.</p> <p>Record review of the facility's policy titled Staffing, dated [DATE], revealed: Our facility provides sufficient numbers of staff with the skills competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment .2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care .</p> <p>Record review of the Facility Assessment Tool dated [DATE], indicated an average daily census of 55. The staffing plan indicated: Licensed Nurses: RN, LPN, LVN providing direct care 3-day shift, 2-evening shift 1-night shift. Nurse Aides: 5-day shift, 4-evening shift, 4-night shift.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 5 residents (Resident #1, Resident #41 and Resident #206) reviewed for pharmaceutical services.</p> <p>The facility failed to ensure Physician Ordered medications were ordered and available for administration for each of the 3 residents (Resident #1, Resident #41 and Resident #206).</p> <p>1. MA E did not administer Resident #1's Pepcid (used to treat gastroesophageal reflux) 20 milligrams medication during a medication pass on 12/03/2024 as ordered by the physician on 06/24/2022.</p> <p>2. MA E did not administer Resident #41's Pepcid (used to treat gastroesophageal reflux) 20 milligrams medication during a medication pass on 12/03/2024 as ordered by the physician on 09/30/2024.</p> <p>3. MA E did not administer Resident #206's Pepcid (used to treat gastroesophageal reflux) 20 milligrams and paroxetine (Paxil) (used to treat depression) 10 milligrams medication during a medication pass on 12/03/2024 as ordered by the physician on 11/30/2024.</p> <p>These failures could place residents at risk of not receiving the intended therapeutic benefit of the medications, decreased quality of life and hospitalization .</p> <p>Findings include:</p> <p>1.Record review of Resident #1's Admission Record, dated 12/3/2024, indicated he was a [AGE] year old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), osteoarthritis (a type of degenerative joint disease that results from breakdown of joint cartilage and underlying bone) and dysphagia (A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink).</p> <p>Record review of Resident #1's physician order, dated 12/03/2024, indicated an order for Pepcid 20 mg, give 2 tablets by mouth one time a day for reflux with a start date of 6/24/2022.</p> <p>Record review of Resident #1's annual minimum data set assessment, dated 11/12/2024, indicated a brief interview for mental status score of 00 out of 15 meaning the resident is rarely/never understood so interview was not conducted.</p> <p>During an observation on 12/3/2024 at 8:36 a.m., revealed MA E did not administer Resident #1's Pepcid during the medication pass as ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #41's Admission Record, dated 12/3/2024, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #41 had diagnoses which included hemiplegia (a symptom that involves one-sided paralysis), dementia (A group of symptoms that affects memory, thinking and interferes with daily life) and type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel).</p> <p>Record review of Resident #41's physician order, dated 12/03/2024, indicated an order for Pepcid 20 mg give 1 tablet by mouth one time a day for reflux with a start date of 9/30/2024.</p> <p>Record review of Resident #41's annual minimum data set assessment, dated 10/11/2024, indicated a brief interview for mental status score of 03 out of 15 which indicated severe cognitive impairment.</p> <p>During an observation on 12/3/2024 at 8:11 a.m., revealed MA E did not administer Resident #41's Pepcid during the medication pass as ordered by the physician.</p> <p>3. Record review of Resident #206's Admission Record, dated 12/3/2024, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #206 had diagnoses which included dementia (A group of symptoms that affects memory, thinking and interferes with daily life), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and gastro-esophageal reflux (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus).</p> <p>Record review of Resident #206's physician order, dated 12/03/2024, indicated an order for Pepcid 20 mg give 1 tablet by mouth two times a day for reflux and Paxil (paroxetine) 10 mg 1 tablet daily for depression with start dates of 11/30/2024.</p> <p>Record review of Resident #206's minimum data set assessment indicated Resident #206 was not available for review due to an admitted [DATE].</p> <p>During an observation on 12/3/2024 at 8:11 a.m., revealed MA E did not administer Resident #206's Pepcid or Paroxetine (Paxil) during the medication pass as ordered by the physician.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and record review on 12/3/2024 at 10:45 a.m., MA E reviewed the medication administration history for Resident #1, Resident #41 and Resident #206 it showed all medications were last given on 12/02/2024. MA A confirmed she did not give Pepcid on 12/3/2024. She said she administered the last Pepcid to another resident earlier and she had not gone to the medication storage room to get another bottle. She stated she was not able to find a replacement bottle at the time of the interview. She said she had not reported needing the over-the-counter medication to the DON and ADON. She said Resident #206 was a new resident and they used the last Paxil (paroxetine) that was sent with her yesterday. She said she had not gone to the medication storage room to see if the resident's medication was sent from the pharmacy. She said the medication aides and charge nurses were responsible for reordering medications and ensuring medications were on the medication carts. She said she made a list of over-the-counter medications that needed to be ordered and gave the list to the charge nurse or the ADON and the person responsible for supplies ordered the medications. She stated when there was one bottle or box of medications on the shelf, they requested the medications were ordered. She said she would reorder prescription medications when there was a seven-day supply left and the reorder button was utilized in the electronic medical records. She said all medication aides were responsible for ordering medications. She stated the pharmacy delivered medications daily to the facility.</p> <p>During an interview with the Assistant Director of Nurses on 12/04/2024 at 11:00 AM, she said she and the DON were responsible for completing the medication aide proficiencies were done on each medication aide within 30 days of hire and annually. She said she was not aware over the counter medications were not available. She stated she did an inventory of all over the counter medications and purchased all medications were needed on 12/04/2024 in the morning. She said all over the counter medications were available prior to the morning medication pass on 12/04/2024. She stated there was a breakdown in communication between the medication aide and management. She said management was not aware that the over-the-counter medications shipment had not been delivered. She said she in serviced the nurses and the medication aides that communication was needed with the management on medications that were missing or not available. Her expectations moving forward was the facility maintained a seven-day supply of all medications to meet the needs of the residents. She said if medications were not given as ordered by the physician, the residents could have a decline in health or an increase in symptoms caused by disease.</p> <p>During an interview with the DON on 12/4/2024 at 11:20 AM, she said she was not aware medications were not available as ordered. She said the charge nurses and medication aides were responsible for ordering medications. She said she and the ADON were ultimately responsible for making sure the supplies and medications needed were available. Her expectations were the staff communicated with management if any supplies or medications were not available. She said possible outcomes of not giving medications as ordered by the physician could result in not following the plan of the care the doctor wanted and it could affect controlling symptoms of disease.</p> <p>In an interview with the Administrator on 12/4/2024 at 11:37 AM, she said the charge nurses and medication aides were responsible for ordering medications and the DON and ADON oversaw that all supplies needed for residents were provided. She said she expected staff to notify management if there were not medications available so the medications could be obtained. She said the outcome of not administering medications as ordered was not following the residents plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Policy #9.1 titled Administration Procedures for all Medications, revised 08/2020, indicated At a minimum, review the 5 rights of medication administration .Five rights of medication administration include: Right drug, right patient, right dose, right route, and right time.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017</p> <p>Based on observation, interview and record review the facility failed to ensure the medication error rates were not 5 percent or greater. The facility had a medication error rate of 15.22%, based on 7 errors out of 46 opportunities, which involved 4 of 5 (Resident #1, Resident #17, Resident #41 and Resident #206) residents and 1 of 1 medication aide (MA E) and 1 of 1 LVN reviewed for medication errors.</p> <ol style="list-style-type: none"> MA E did not administer Resident #1's Pepcid during the medication pass as ordered by the physician on 12/3/24 due to medication not available. MA E failed to administer the correct dose of vitamin C to Resident #17 on 12/03/2024 as ordered by the physician and mixing a medications and protein supplement (polypharmacy) together instead of preparing them individually. MA E did not administer Resident #41's Pepcid during the medication pass as ordered by the physician on 12/3/24 due to medication not available. MA E did not administer Resident #206's Pepcid or Paxil during the medication pass as ordered by the physician on 12/3/24 due to medication not available. <p>These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of Resident #1's Admission Record, dated 12/3/2024, indicated he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), osteoarthritis (a type of degenerative joint disease that results from breakdown of joint cartilage and underlying bone), and dysphagia (A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink). <p>Record review of Resident #1's physician order, dated 12/03/2024, indicated an order for Pepcid 20 mg, give 2 tablets by mouth one time a day for reflux with a start date of 6/24/2022.</p> <p>Record review of Resident #1's annual minimum data set assessment, dated 11/12/2024, indicated a brief interview for mental status score of 00 out of 15 meaning Resident #1 was rarely/never understood so interview was not conducted.</p> <p>During an observation on 12/3/2024 at 8:36 a.m., revealed MA E did not administer Resident #1's Pepcid during the medication pass as ordered by the physician.</p> <p>(continued on next page)</p>		

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 12/04/2024
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n Gilmer, TX 75644	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #17's Admission Record, dated 12/3/2024, indicated an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included lymphocytic leukemia (a type of cancer that starts in early forms of certain white blood cells [called lymphocytes] in the bone marrow), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and atrial fibrillation (an irregular and often very rapid heart rhythm).</p> <p>Record review of Resident #17's Physician order, dated 12/03/2024, indicated an order for Vitamin C 500 mg give 1000 mg by mouth one time a day for supplement start date of 4/13/2024, active-protein supplement 30 cc two times daily start date of 8/24/2024, MiraLAX powder 17GM/scoop give 1 scoop one time a day for constipation start date of 9/14/2023, and Lactulose oral solution 10 GM/15 ml give 30 ml by mouth one time a day for constipation with a start date of 1/21/2024.</p> <p>Record review of Resident #17's quarterly minimum data set assessment, dated 09/26/2024, indicated a brief interview for mental status score of 00 out of 15 meaning resident was rarely/never understood.</p> <p>During an observation on 12/3/2024 at 8:21 a.m., MA E administered vitamin C 500 mg 1 tablets to Resident #17 instead of the order vitamin C 1000 mg 1 tablets one time a day. Lactulose 10mg/15 ml, MiraLAX oral powder 17mg / scoop and active protein supplement was mixed in a cocktail with unknown amount of water poured into the cup and given with approximately 30 ml of mixture refused by resident.</p> <p>3. Record review of Resident #41's Admission Record, dated 12/3/2024, indicated a 68year-old male who was admitted to the facility on [DATE]. with diagnoses of hemiplegia (a symptom that involves one-sided paralysis), dementia (A group of symptoms that affects memory, thinking and interferes with daily life), and type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel).</p> <p>Record review of Resident #41's physician order, dated 12/03/2024, indicated an order for Pepcid 20 mg give 1 tablet by mouth one time a day for reflux with a start date of 9/30/2024.</p> <p>Record review of Resident #41's annual minimum data set assessment, dated 10/11/2024, indicated a brief interview for mental status score of 03 out of 15, which indicated severe cognitive impairment.</p> <p>During an observation on 12/3/2024 at 8:11 a.m., revealed MA E did not administer Resident #41's Pepcid during the medication pass as ordered by the physician.</p> <p>4. Record review of Resident #206's Admission Record, dated 12/3/2024, , indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #206 had diagnoses which included dementia (A group of symptoms that affects memory, thinking and interferes with daily life), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and gastro-esophageal reflux (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus).</p> <p>Record review of Resident #206's physician order, dated 12/03/2024, indicated an order for Pepcid 20 mg give 1 tablet by mouth two times a day for reflux and Paxil 10 mg 1 tablet daily for depression with start dates of 11/30/2024.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #206's minimum data set assessment revealed one was not available for review due to admitted [DATE].</p> <p>During an observation on 12/3/2024 at 8:11 a.m., MA E did not administer Resident #206's Pepcid or Paxil during the medication pass as ordered by the physician.</p> <p>During an interview and record review on 12/3/2024 at 10:45 a.m., MA E confirmed she did not give Pepcid on 12/3/2024. She did not report it to the charge nurse but did chart it in the medication administration record. She said she administered the last Pepcid to another resident earlier and she had not gone to the medication storage room to get another bottle. She stated she was not able to find a replacement bottle at the time of the interview. She said she had not reported needing the over-the-counter medication to anyone. She said Resident #206 was a new resident and they used the last Paxil that was sent with her yesterday. She said she had not gone to the medication storage room to see if the resident's medication had been sent from the pharmacy. She said she mixed Resident #17 protein, lactulose and MiraLAX together when she administered the medication because he would normally take all the medications together. She said she did not know the amount of each medication was given with the 30 ml left in the cup. She said the resident normally took all of the mixture or he would refuse all of the medications. She said she was instructed to give medications individually during her training. She stated she mixed his together to encourage him to take all of them.</p> <p>During an interview with the Assistant Director of Nurses on 12/04/2024 at 11:00 AM, she said she and the DON were responsible for completing the medication aide proficiencies were done on each medication aide within 30 days of hire and annually. She said she was not aware over the counter medications were not available. She stated she did an inventory of all over the counter medications and purchased all medications that were needed on 12/04/2024 in the morning. She said all over the counter medications were available prior to the morning medication pass on 12/04/2024. She said the staff responsible for passing medications were trained to give all medications as ordered. She said liquid medications should be given individually and not mixed unless indicated by the physician's orders. Her expectations moving forward was for the staff administering medications follow the physician's orders and follow the five rights of medication administration. She said if medications were not given as ordered by the physician, the residents could have a decline in health or an increase in symptoms caused by disease.</p> <p>During an interview with the DON on 12/4/2024 at 11:20 AM, she said she was not aware medications were not available as ordered. She said the charge nurses and medication aides were responsible for ordering medications. She said she and the ADON were ultimately responsible for making sure the supplies and medications needed were available. Her expectations were the staff communicates with management, if any supplies or medications were not available. She expected the staff to follow the five rights of medication administration. She said possible outcomes of not giving medications as ordered by the physician could result in not following the plan of the care the doctor wanted and it could affect controlling symptoms of disease.</p> <p>In an interview with the Administrator on 12/4/2024 at 11:37 AM, she said the charge nurses and medication aides were responsible for ordering medications and the DON and ADON oversaw all supplies needed for residents were provided. She said she expected staff to notify management if there were not medications available so the medications could be obtained. She said the outcome of not administering medications as ordered is not following the residents plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Policy #9.1 titles Administration Procedures for all Medications revised 08/2020 indicated At a minimum, review the 5 rights of medication administration. Five rights of medication administration include: Right drug, right patient, right dose, right route, and right time.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</p> <p>Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure food stored in the kitchen refrigerator was labeled, dated and not expired. 2. The facility failed to ensure food stored in the kitchen dry storage area was not expired. <p>These failures could place residents at risk for foodborne illness.</p> <p>Findings include:</p> <p>During an observation on [DATE] at 09:25 AM, revealed the #2 refrigerator contained a clear plastic bag of black olives with an opened date of [DATE] that was ,d+[DATE] full and a tray of what appeared to be 2 heads of lettuce covered with a clear plastic wrap that was not labeled or dated.</p> <p>During an observation on [DATE] at 09:25 AM of the dry storage area revealed a clear plastic bag of [NAME] cracker crumbs, 5-pound bag that was approximately ,d+[DATE] full with an open date of [DATE] and a use by date of [DATE], 10 packages of flour tortillas 12 count package with the expiration date of [DATE], and 1 package of coffee, 10 filter pack with the expiration date of [DATE].</p> <p>During an interview on [DATE] at 10:04 AM, the [NAME] said she had worked at the facility since [DATE]. She said usually when the delivery truck came in, the kitchen staff were supposed to look at expiration dates and mark the products with the received dates. She said they were supposed to have a set date or schedule to look at all products in the kitchen to make sure all expired foods were discarded. She said if she found any expired products, she notified the DM and then threw it away. She said the cook was supposed to check in the kitchen and the aides were supposed to check the dry storage area for expired foods. She said the process had not been happening consistently. She said she told the dietary aides to go and check the dry storage area for expired foods, but they forgot to check. She said all food in the kitchen was supposed to be labeled and dated when received or opened. She said the residents could potentially get sick from food borne illness if they consumed expired foods.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 10:11 AM, the DM said she had worked at the facility for about 2 weeks. She said when the food trucks came in, the kitchen staff checked for the expiration dates and rotated the food. She said all food in the kitchen should be labeled and dated with the received and opened date. She said all food in the kitchen was supposed to be checked every Wednesday for expiration dates. She said she was working on orientation of the kitchen staff for food storage and the proper way to put the truck delivery food away properly. She said it was everyone's responsibility to check for expiration dates of the food. She said every time they used something, the expiration dates were supposed to be checked. She said it was her responsibility to check for the expired foods weekly. She said residents could potentially become sick from a food borne illness by consuming expired foods.</p> <p>During an interview on [DATE] at 11:01 AM, the Administrator said her expectation was for the kitchen staff to check for expired foods daily and weekly when they received their food delivery truck. She said it was the DM's responsibility to make sure there was not any expired foods in the kitchen or dry storage area. She said the cooks were also supposed to check for expired foods. She said it could make residents sick to consume expired foods.</p> <p>Record review of the facility policy titled Food Storage, dated [DATE], indicated: All food purchased will be wholesome, manufactured, processed, and prepared in compliance with all State, Federal, and local laws and regulations. Food will be handled in a safe and sanitary method to prevent contamination and food-borne illness .3 . Foods will be used or discarded prior to the expiration date.6. Food removed from its original packaging will be labeled with the following: a. Receive Date b. Open Date c. Contents in the Package .9. Opened package or leftover food is to be tightly wrapped or covered in airtight, clean containers. It should be labeled, dated with the opened or use by date. Do not keep leftovers in the refrigerator for more than 7 days.</p> <p>The Food and Drug Administration Food Code dated 2017 reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE].11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</p> <p>Based on observation, interview and record review the facility failed to have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption for three of twelve Residents (Resident #21, Resident #42 and Resident #23) reviewed for food and nutrition services.</p> <ol style="list-style-type: none"> The facility failed to ensure the refrigerator for Resident #21 was clean and contained food items that were labeled and dated. The facility failed to ensure the refrigerator for Resident #42 did not contain expired broccoli cheddar soup. The facility failed to ensure the refrigerator for Resident #23 did not contain expired peaches and pears. <p>These failures could place residents at risk for foodborne illness.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of Resident #21's face sheet, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #21 had diagnoses which included: chronic systolic heart failure (the heart does not pump enough blood to the body) and vascular dementia (reduced blood flow to the brain). <p>Record review of Resident #21's quarterly MDS, dated [DATE], indicated Resident #21's BIMS was 14, which indicated no cognitive impairment.</p> <p>Record review of Resident #21's, undated, care plan indicated: Resident may be at risk for an altered nutritional status, weight loss, dehydration, altered labs . with interventions that included: Encourage fluid intake, offer fluids resident likes as much as possible.</p> <ol style="list-style-type: none"> Record review of Resident #42's face sheet, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #42 had diagnoses which included: end stage renal disease (kidneys no longer function), severe protein calorie malnutrition (deficient in both protein and calories) and iron deficiency anemia (not enough iron to produce healthy red blood cells). <p>Record review of Resident #42's quarterly MDS, dated [DATE], indicated Resident #42's BIMS was 6, which indicated severe cognitive impairment.</p> <p>Record review of Resident #42's, undated, care plan indicated: Resident is on a carb controlled pureed therapeutic diet with large meat/egg portions with nectar thick liquids per his preference . with interventions that included: offer snacks within diet and serve diet as ordered and offer substitute if less than 50% is eaten.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #23's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #23 had diagnoses which included: malignant neoplasm of cecum and colon (cancerous tumor), vitamin deficiency (long-term lack of a vitamin), and muscle wasting (loss of muscle tissue).</p> <p>Record review of Resident #23's quarterly MDS, dated [DATE], indicated Resident #23's BIMS score was 5, which indicated severe cognitive impairment.</p> <p>Record review of Resident #23's, undated, care plan reflected: Resident may be at risk for an altered nutritional status, weight loss, dehydration, altered labs or skin breakdown related to diagnoses, meds, diet, and appetite .with interventions that included: Encourage fluid intake, offer fluids resident likes as much as possible.</p> <p>During an observation and interview on [DATE] at 10:00 AM, Resident #23 said his family brought him food to store in his refrigerator. He said he was not aware of any expired food in the refrigerator. He said staff members checked the refrigerator for him every day. Observation of Resident #23's personal refrigerator revealed 2 cups of peaches and 2 cups of pears all of which had the expiration date of [DATE].</p> <p>During an observation and interview on [DATE] at 11:14 AM, Resident #21 said his personal fridge was dirty and needed to be cleaned. Resident #21 said he tried to keep his fridge clean himself, but staff would help him clean it sometimes. He said the food that was in the fridge was old. Resident #21 said he got food out of the fridge by himself. Observation of Resident #21's personal fridge was noted to be dirty with an orange sticky substance spilled in the bottom of the fridge. There was one cup of an unknown substance that was not covered, labeled or dated. There were several plastic bags filled with what appeared to be left over desserts from the kitchen. There were two covered bowls of what appeared to be left over desserts from the kitchen that were not labeled or dated, with one of the bowls laying on its side with the contents spilled out into the fridge. The freezer compartment contained one plastic packaging of an unknown item, due to the ice buildup being so thick the item could not be removed from the freezer.</p> <p>During an observation and interview on [DATE] at 11:15 AM, Resident #42 said his family member came to the facility every day and brought him food that she thought he might like to eat. He said sometimes his family member cleaned out the fridge and sometimes staff helped him by cleaning out his fridge. He said he could not reach the fridge and his family member or staff got things out of the fridge for him. He said the broccoli cheddar soup with the expiration date of [DATE] was in the fridge for a while but he did not plan on eating it.</p> <p>During an interview on [DATE] at 11:00 AM, Housekeeper K said it was housekeeping's responsibility to check all resident's personal refrigerators daily for temperature and cleanliness, but they did not check for expired foods.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:30 AM, the Maintenance Director said he was the supervisor over housekeeping and was responsible for all housekeeper staff training. He said he worked with new staff members for a couple of days and then they worked with a more experienced staff member until they were competent to work alone. He said housekeeping staff were trained and expected to check all personal resident refrigerators daily for temperature, cleanliness and expired foods. He said staff signed a log sheet attached to each refrigerator indicating daily checks were completed. He said the residents could get sick if they consumed expired foods. He said going forward he would retrain staff to make sure policies were followed.</p> <p>During an interview on [DATE] at 10:22 AM, the DON said resident personal fridges needed to be cleaned at least once a week, with freezers defrosted and expired foods discarded. She said it was housekeeping's responsibility to maintain the residents' personal fridges. She said she did not know why it had not been done. She said that issue had been brought up in their daily meetings recently and they talked to the housekeeping manager about keeping the personal fridges cleaned. She said if residents consumed expired foods from the personal fridges, it could potentially make the resident sick. The DON said going forward her expectation was for the personal fridges to be cleaned weekly and would be putting out a cleaning schedule.</p> <p>During an interview on [DATE] at 11:01 AM, the Administrator said she knew housekeeping cleaned some of the personal fridges. She said they had focused partner rounds were staff made rounds to check on residents and should be looking at the fridges daily. She said it could make a resident sick if they ate something from the personal fridge that was not good. She said her expectation going forward was the personal fridges would be checked through daily focused partner rounds.</p> <p>During an interview on [DATE] at 11:01 AM, the ADON said it was housekeeping's responsibility to keep personal fridges clean and free of expired foods. She said the Maintenance Director recently took over as the housekeeping supervisor. She said the residents could get sick by consuming expired foods.</p> <p>Record review of the facility policy titled Food from Outside Sources, revised last on ,d+[DATE], reflected the following:</p> <ul style="list-style-type: none"> .Community personnel will be responsible for the managing of appropriate temperatures & food stored in resident refrigerator. .Proper Storage <ul style="list-style-type: none"> i. Cold items stored in resident refrigerator & discarded appropriately based on labeled dates and/or 3 days after opening to prevent food borne illness ii. Dry goods properly sealed to prevent pests & discarded appropriately based on labeled dates <p>Record review of Refrigerator Check Sheets for Residents #42, #23, and #21 indicated the refrigerators had been checked daily.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017</p> <p>Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 7 residents (Resident #1, #17, #41, and #206) and 3 of 5 staff (MA E, CNA C, and CNA D) reviewed for infection control.</p> <ol style="list-style-type: none"> CNA C and CNA D failed to change gloves and perform hand hygiene during incontinent care for Resident #17 on 12/02/2024. MA E failed to sanitize her hands while administering medications to Resident # 1, Resident #17, Resident #41 and Resident #206 on 12/03/24. MA E failed to clean and disinfect the blood pressure cuff used on Resident #17 and Resident #41 after use during medication pass on 12/3/2024. <p>These failures could place residents at risk of exposure to infectious diseases.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of Resident #17's Admission Record, dated 12/3/2024, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included lymphocytic leukemia (a type of cancer that starts in early forms of certain white blood cells called y in the bone marrow), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and atrial fibrillation (an irregular and often very rapid heart rhythm). <p>Record review of Resident #17's quarterly minimum data set assessment, dated 09/26/2024, indicated a brief interview for mental status score of 00 out of 15 due to the resident was rarely/never understood.</p> <p>Record review of Resident #17 comprehensive care plan, dated 10/25/2024, reflected Resident #17 was incontinent of bowel and bladder and required incontinent care from the staff.</p> <p>During an observation on 12/02/24 at 10:00 AM revealed CNA C and CNA D provided incontinent care to Resident #17. Both entered the room and applied gowns and gloves for enhanced barrier precautions. CNA C opened Resident #17's brief and cleaned the front with wipes using a front to back technique. CNA D assisted Resident #17 to his right side. CNA C then cleaned Resident #17's buttock with wipes and the soiled brief and draw sheet was rolled under Resident #17. CNA C then placed a clean sheet and brief without removing her gloves or performing hand hygiene. CNA C proceeded to apply the clean brief. Resident #17 was positioned to his left side by CNA D and CNA C removed the soiled draw sheet and brief. She positioned the clean draw sheet and brief under Resident #17. CNA C and CNA D positioned Resident #17 in bed and adjusted Resident #17's pillows and linen. CNA C and CNA D removed their gloves and gown and left the room with the soiled linen and brief contained in a plastic bag. CNA C and CNA D did not sanitize their hands until they were in the hallway.</p> <p>(continued on next page)</p>

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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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/02/24 at 10:10 AM, CNA C said she had been a CNA for 2 months. She said she was recently checked off on incontinent care and infection control when she was hired. She said during incontinent care she should have removed her gloves and performed hand hygiene when going from soiled to clean. She said she did not follow the infection control protocol because she was nervous. She said by not doing so she could cause spread of infections.</p> <p>During an interview on 12/02/24 at 10:13 AM, CNA D said she had been a CNA for 7 years. She said the facility performed checked off on incontinent care and infection control with the CNA's annually. She said during incontinent care she should have removed her gloves and performed hand hygiene when going from soiled to clean. She said by not doing so she could cause spread of infections.</p> <p>Record review of a CNA Proficiency Audit, dated 10/30/202, for CNA C and CNA D, indicated they demonstrated satisfactory proficiency with infection control, proper handwashing, and perineal care by the ADON.</p> <p>2.</p> <p>Record review of Resident #1's Admission Record, dated 12/3/2024, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), osteoarthritis (a type of degenerative joint disease that results from breakdown of joint cartilage and underlying bone) and dysphagia (A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink).</p> <p>Record review of Resident #1's annual minimum data set assessment, dated 11/12/2024, indicated a brief interview for mental status score of 00 out of 15 due to the resident was rarely/never understood.</p> <p>Record review of Resident #41's Admission Record, dated 12/3/2024, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #41 had diagnoses which included hemiplegia (a symptom that involves one-sided paralysis), dementia (A group of symptoms that affects memory, thinking and interferes with daily life) and type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel).</p> <p>Record review of Resident #41's annual minimum data set assessment, dated 10/11/2024, indicated a brief interview for mental status score of 03 out of 15, which indicated severe cognitive impairment.</p> <p>Record review of Resident #206's Admission Record, dated 12/3/2024, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #206 had diagnoses which included dementia (A group of symptoms that affects memory, thinking and interferes with daily life), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and gastro-esophageal reflux (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus).</p> <p>Record review of Resident #206's minimum data set assessment reflected it was not available for review due to an admitted [DATE].</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a medication administration observation on 12/03/2024 from 8:00 AM to 8:50 AM revealed MA E did not wash or sanitize her hands before unlocking the medication cart to get medications for Resident #1, Resident #17, Resident #41 and Resident #206. MA E was observed opening medication cart drawers, picking up multiple medication bottles, medication cards and a nasal spray. She was observed locking the medication cart between each resident. MA E failed to sanitize hands during observation period.</p> <p>During medication administration observation on 12/03/2024 at 8:11 AM, MA E used a blood pressure cuff placed on the wrist of Resident #41 and did not sanitize after use. At 8:21 AM the same blood pressure cuff was placed on the wrist of Resident #17 and was not sanitized before or after use.</p> <p>During an interview on 12/03/2024 at 10:00 AM, MA E said she had been employed at the facility for 2 years. She said the ADON did a check off with her on medication administration when she was hired, and it is done annually. She said during the observation of medication pass, she should have sanitized her hands before she opened the cart, and before and after administering medications to each resident. She said sanitizer was in her cart, but she was nervous and did not sanitize her hands. She said she should have sanitized the blood pressure cuff after every use, but she was nervous and did not think about it. She said residents could be at risk for transfer of germs and possible diseases.</p> <p>During an interview on 12/04/2024 at 11:00 AM, the ADON said she and the DON were responsible for conducting skill check offs with staff. She said the check offs were conducted on hire and annually. She said hand hygiene during medication administration should be conducted before, between, after each resident and any time hands were visibly soiled. She said blood pressure cuffs should be cleaned between each resident. She said hand hygiene and glove changes should be done during incontinent care when touching dirty to clean items and it should be done as often as needed. She said residents could be at risk for infections with staff spreading germs by not washing or sanitizing their hands and equipment.</p> <p>During an interview on 12/04/2024 at 11:10 AM, the DON said she and the ADON were responsible for conducting skill check offs with staff. She said hand hygiene and infection control were topics that were reviewed frequently. She said the check offs were conducted on hire and annually. She said hand hygiene during medication administration should be conducted before, between, after each resident and any time hands were visibly soiled. She said blood pressure cuffs should be cleaned between each resident. She said hand hygiene and glove changes should be done during incontinent care when touching dirty to clean items. She said residents could be at risk for infections with staff spreading germs by not washing or sanitizing their hands and equipment.</p> <p>During an interview on 12/04/2024 at 11:30 AM, the Administrator said the ADON, and the DON were responsible for providing education with in-service training and return demonstration to all staff on hand hygiene. She said hand hygiene should be done before, after, and in between residents and any time going from dirty to clean. She said going forward they would continue to monitor for compliance and with return demonstration on hand hygiene. She said residents could be at risk for infections.</p> <p>Record review of a Medication Aide Proficiency Audit, dated 11/11/2024, for MA E indicated she demonstrated satisfactory proficiency with infection control and proper handwashing by the ADON.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled Handwashing/Hand Hygiene revised August 2019, .use an alcohol-based hand rub containing at least 62% alcohol or soap and water .b. Before and after direct contact with residents . i. after contact with resident's intact skin .l. after contact with objects in the immediate vicinity of the resident m. after removing gloves</p> <p>Record review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revised October 2028 reflected .Reusable resident care equipment will be decontaminated and /or sterilized between residents</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436</p> <p>Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relayed the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities for 2 of 18 residents (Residents #107 and #110) reviewed for call lights .</p> <p>The facility failed to ensure Residents #107 and #110's bathrooms had a call light pull cord on 12/02/2024 and 12/03/2024.</p> <p>This failure could place residents at risk of injury, pain, hospitalization , and a diminished quality of life.</p> <p>Findings include:</p> <p>1. Record review of Resident #107's facility face sheet, dated 12/04/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #107 had a diagnosis which included hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness following a stroke).</p> <p>Record review of Resident #107's comprehensive care plan, dated 11/25/2024, revealed Resident#107 was high risk for increased falls and fractures and ensure resident's call light was within reach and encourage the resident to use it for assistance as needed.</p> <p>Record review of Resident #107's admission MDS assessment, dated 11/29/2024, revealed Resident #107 had a BIMS of 14, which indicated intact cognition. Resident #107 was continent of bowel and bladder and required moderate assistance with toileting.</p> <p>2. Record review of Resident #110's facility face sheet, dated 12/04/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #110 had a diagnosis which included chronic obstructive pulmonary disease (lung disease that causes shortness of breath).</p> <p>Record review of Resident #110's comprehensive care plan, dated 11/20/2024, revealed Resident #110 was a moderate risk for increased falls and ensure resident's call light was within reach and encourage the resident to use it for assistance as needed.</p> <p>Record review of Resident #110's admission MDS assessment, dated 11/25/2024, revealed Resident #110 had a BIMS of 15, which indicated intact cognition. Resident #110 was continent of bowel and bladder and was dependent on toileting.</p> <p>During an observation on 12/02/24 at 11:18 AM revealed Resident #107 and Resident #110 did not have a call light pull cord attached to their bathroom call system.</p> <p>During an observation on 12/03/24 at 8:22 AM revealed Resident # 107's bathroom call light did not have a pull cord.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/03/24 at 8:24 AM revealed Resident #110 was observed in her bathroom alone performing ADL care and there was no bathroom call light pull cord in place .</p> <p>During an interview on 12/02/24 at 2:19 PM, Resident #107 said he used his bathroom and had to push the button for help but if he was to fall, he did not know how he would get help other than yell.</p> <p>During an interview on 12/02/24 at 2:30 PM, Resident #110 said she used her bathroom and had not noticed there was no cord in the bathroom. She said if she were to fall, she would have to yell for help if there was no cord to pull.</p> <p>During an interview on 12/03/24 at 9:18 AM, CNA B said she had been a CNA for [AGE] years and had worked at the facility for 3 years. She said call lights should be checked on all rounds by anyone who entered the residents room. She said she had not noticed there was no cord to the call light in Resident #107 and #110's bathrooms. She said both residents used their bathroom and if they were to fall, they would not be able to get help, delaying care. She said she thought the Maintenance Director was responsible for checking call lights and installing the pull cords. She said there was a work order book for maintenance, but she was not sure if anyone had notified him or the missing pull cords.</p> <p>During an interview on 12/03/24 at 12:05 PM, the Maintenance Director said he was hired June 2023 and was responsible for ensuring all call lights in the bedrooms and bathrooms were in working order. He said he was not aware of the missing cords in the bathrooms for Residents #107 and #110 and no one had put in a work order. He said he checked the call lights in the facility at least monthly. He said not having a call light pull cord in the bathroom could delay care if the resident were to fall and could not call for help.</p> <p>During an interview on 12/04/24 at 11:55 AM, the Administrator said the Maintenance Director was responsible for making rounds on call lights and the staff should also be completing work orders for any repairs and replacement of call light cords. She said call lights should be checked daily by all staff. She said if call lights were not able to be activated it could cause a delay in staff getting to the resident for care and expected all bathrooms had a call light cord, were monitored daily, and reported to maintenance if there was a problem.</p> <p>Record review of the facility's policy titled Bedrooms, dated May 2017, indicated, .all resident rooms are equipped with a resident call system that allows residents to call for staff assistance</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>50818</p> <p>Based on interview and record review the facility failed to ensure as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program for 2 of 15 employees (CNA G and CNA L) reviewed for training.</p> <p>The facility failed to ensure the quality assurance and performance improvement training was provided to CNA G and CNA L.</p> <p>This failure could place residents at risk for not being aware of facility programs, implementation, and monitoring.</p> <p>Findings include:</p> <p>Record review of CNA G's personnel file revealed CNA G was hired on 7/13/2017 and had not completed annual QAPI training .</p> <p>Record review of CNA L's personnel file revealed CNA L was hired on 2/06/2024 and had not completed QAPI training.</p> <p>During an interview on 12/05/2024 at 2:30 PM, the ADON said she was responsible for overseeing the on hire and annual trainings and was not aware of the required annual QAPI training not being completed for CNA G and CNA L. She stated she used a binder to manually record and keep track of required training. She said if staff were not properly trained it could affect resident care .</p> <p>During an interview on 12/05/2024 at 2:40 PM, the Administrator stated she was ultimately responsible for oversight of all trainings. She said trainings were assigned by the ADON and she generated a monthly report to monitor incomplete required trainings. She stated she was not aware that CNA G and CNA L had not completed required QAPI trainings but would work with the corporate education director to ensure every employee completed required training. She stated staff who were not trained could affect resident care and expected all staff to complete required regulated trainings annually and on hire .</p>		