STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675602	A. Building B. Wing	02/25/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review the facility failed to provide care and services in accordance with activities of daily living for hygiene-bathing, dressing, grooming, and oral care for residents a during a confidential interview for 13 of 13 residents (Unidentified Resident #1, Unidentified Resident #2, Unidentified Resident #3, Unidentified Resident #4, Unidentified Resident #5, Unidentified Resident #6, Unidentified Resident #7, Unidentified Resident #8, Unidentified Resident #9, Unidentified Resident #10, Unidentified Resident #11, Unidentified Resident #12, Unidentified Resident #13)reviewed for ADLs. The facility failed to ensure the residents had a sufficient number of towels in the facility for ADL care. This failure could place residents at risk of no showers, hand hygiene, not receiving services/care and decreased quality of life. Findings include:A record review of the facility in-service binder, no in-services were noted related to the facility not having towels available for the resident's hygiene needs. A record review of the facility invoice indicated, washcloths and towels orders were made to distributor in November of 2025, but the towels were on back order. During an observation on 2/24/26 at 9:47 A.M., on Hall 200 linen cart, revealed there were no towels on the cart. During an observation on 2/24/26 at 9:49 A.M., on Hall 300 linen cart, revealed there were no towels on the cart. During an observation on 2/24/26 at 9:55 A.M., on Hall 400 linen cart, revealed there were no towels on the cart. During an observation on 2/24/26 at 11:06 A.M., on Hall 100 linen cart, revealed there was one bath towel on the cart. During an observation on 2/24/26 at 11:08 A.M., on Hall 200 linen cart, revealed there was one face towel and two bath towels on the cart. During an observation on 2/24/26 at 11:09 A.M., on Hall 300 linen cart, revealed there were two face towels and three bath towels on the cart. During an observation on 2/24/26 at 11:12 A.M., on Hall 400 linen cart, revealed there were no towels on the cart. During confidential interview 13 of 13 residents (Unidentified Resident #1, Unidentified Resident #2, Unidentified Resident #3, Unidentified Resident #4, Unidentified Resident #5, Unidentified Resident #6, Unidentified Resident #7, Unidentified Resident #8, Unidentified Resident #9, Unidentified Resident #10, Unidentified Resident #11, Unidentified Resident #12, Unidentified Resident #13) voiced the facility often did not have towels available and CNAs were not giving residents their showers due to a lack of washcloths and bath towels supplied by the facility. The residents said they complained about the issue, but the situation had not gotten better. During an interview on 2/24/26 at 9:35 A.M., CNA B said towels were hard to find every day and staff had to hunt for them in the facility. CNA B said the Director of Environmental Service was responsible for ordering the towels. She said a negative effect of not having towels available in the facility was that staff could not get the residents up for showers or bathe them and could not wash the residents' face and hands in the morning. During an interview on 2/24/26 at 9:35 A.M., Laundry Aide F said she thought there were not enough towels and washcloths in the facility, but her supervisor, the Director of Environmental Services, said a shipment would be on the next day. She said the facility had a shortage of towels and washcloths. She said the Director of Environmental Services was her supervisor and she was responsible for ensuring the facility had enough towels. She said a negative effect of not having an adequate number of towels was the aides were not able to give residents showers or wash their faces in the mornings and the aides could not provide the appropriate care, (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because they did not have what they need to perform their job. During an interview on 2/24/26 at 11:30 A.M., the Director of Environmental Services said since November she had taken over, and she had ordered towels every month. She said she put in an order for towels every month since November. She said she had not received any towels since November. She said the facility was supposed to get 75 towels and 120 washcloths today or tomorrow. She said she expected the residents to have towels. She said she told the Director of Plant Operations what she needed, and he ordered it for her, because she did not have access to ordering materials. She said a negative effect of the residents not having towels available was the residents were not getting the care they needed, because the aides did not have the linen supply. During an interview on 2/24/26 at 11:38 A.M., LVN E said the aides were supposed to have towels for the residents, often the aides did not have towels. She said laundry was responsible for ensuring the aides had towels washed and supplied. She said the risk of not having towels available was infection and residents not being able to take baths. During an interview on 2/24/26 at 3:00 P.M., LVN A said she expected the aides and residents to have towels. She said laundry and housekeeping were responsible for getting the laundry out. She said the risk of not having the appropriate supply of towels would be skin breakdown if the residents did not get their showers. During an interview on 2/25/26 at 9:54 AM, the Director of Plant Operations said he expected residents to have towels. He said the towels were on back order for several months now from the company the facility ordered. He said he was responsible for ordering the towels. He showed the state surveyor where the towels were on back order. He said the distributor gave them an option to get a different line of towels ordered. He said a risk was the residents would not have towels for hygiene care. He said the towels were ordered, and the facility should receive them today. During an interview on 2/25/26 at 10:33 A.M., the Director of Clinical Operations said she expected towels to be available for the residents. She said housekeeping and the Environmental Services Manager were responsible for ensuring the appropriate number of towels were available. She said the risk was residents missing showers and could cause skin issues. During an interview on 2/25/26 at 10:55 A.M., the Executive Director of Operations said she expected the staff to have an appropriate number of towels to take care of the residents. She said housekeeping management was responsible for ensuring the towels were in the facility. She said the negative effect was increased infection. Record review of the facility's policy and procedure Quality of Life- Accommodation of Needs, dated August 2009, indicated .Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being. The residents' individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care were provided with such care, consistent with professional standards of practices for 3 of 25 residents (Resident #14, Resident #35, and Resident #2) reviewed for respiratory care.The facility failed to ensure that oxygen filters were clean for Resident #14's oxygen concentrator.The facility failed to change the oxygen tubing for Resident #35's oxygen concentrator.The facility failed to ensure Resident #2's oxygen reservoir was changed weekly.These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care.1. Record review of Resident #14's face sheet, dated 01/02/26 revealed a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included Chronic Obtrusive Pulmonary Disease (a progressive, irreversible lung disease causing chronic, long-term breathing problems, typically characterized by chronic bronchitis, emphysema, or both), Sepsis (a life-threatening, emergency response to infection where the immune system damages the body's own tissues and organs), and Urinary Tract Infection (a common bacterial infection in the bladder, kidneys, or urethra, often causing painful, burning urination, frequent urges, and cloudy or strong-smelling urine.) Record review of Resident #14's quarterly MDS assessment, dated 1/4/26, revealed Resident #14 had a BIMS score of 15, which indicated she was cognitively intact. Shows that Resident #14 required oxygen therapy. Record review of Resident #14's care plan dated 1/5/2026 indicated that, Ineffective Breathing Pattern related to: Chronic Obtrusive Pulmonary Disease. Resident will demonstrate an effective respiratory rate, depth, and pattern, and increased activity tolerance throughout the review date. Record review of an phyisidan's order for Resident #14, dated 1/2/26, shows that an order was placed for, Oxygen at 2 liters per nasal cannula to maintain peripheral capillary oxygen saturation greater than 90%. Record review of an physician's order for Resident #14, dated 1/2/26, shows that an order was placed for, Clean/change oxygen concentrator filters every night shift every Sunday. During an observation and interview on 2/22/26 at 10:14 a.m. Resident # 14 said that she did not know when her oxygen concentrator was cleaned by staff. It was observed that the oxygen concentrator filter was covered in dust and dirt. During an observation on 2/23/26 at 12:55 p.m. of Resident #14's oxygen concentrator, it was observed that the oxygen concentrator filter was still covered in dust and dirt. 2. Record review of Resident #35's face sheet, dated 12/28/24 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included Acute and Chronic Respiratory Failure with Hypercapnia (occurs when a patient with underlying chronic respiratory insufficiency (e.g., COPD, pulmonary fibrosis) suffers a sudden, severe decline in lung function, often due to an infection or exacerbation), Acute Pulmonary Edema (a life-threatening, sudden buildup of fluid in the lungs' air sacs, usually caused by rapid heart failure (cardiogenic) or lung injury), Cognitive Communication Deficit (difficulties with verbal and non-verbal communication caused by underlying impairments in thinking skills—such as memory, attention, organization, and reasoning—rather than (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	primary language disorders). Record review of Resident #35's quarterly MDS assessment, dated 1/27/26, revealed Resident #35 had a BIMS score of 03, which indicated severely impaired cognition. Shows that resident #35 required oxygen therapy on admission and while a resident. Record review of Resident #35's care plan dated 1/23/26 shows a lack of care planning regarding oxygen use. Care plan did not document oxygen therapy or oxygen usage. Record review of an order for Resident #35, dated 10/21/25, shows that an order was placed for, Oxygen at 2 liters per nasal cannula to maintain peripheral capillary oxygen saturation greater than 90% Record review of an order for Resident #35, dated 10/21/25, shows that an order was placed for, Oxygen tubing change every night shift every Sunday for tubing. During an observation on 2/22/26 at 10:46 a.m. Resident # 35 was asleep in her wheelchair. She had her oxygen concentrator turned on and providing oxygen via nasal. The label for the oxygen concentrator read 2/16/26. During an observation and interview on 2/23/26 at 9:10 a.m. Resident # 35 was sitting in her wheelchair watching TV. She had oxygen concentrator on and nasal cannula providing oxygen. The label for the oxygen concentrator read 2/16/26. She said she did not know if staff changed her oxygen tubing, but she does use it every day. During an observation on 2/23/26 at 1:00 p.m. Resident #35's The label for the oxygen concentrator still read 2/16/26. During an interview on 2/25/26 at 9:30 a.m. with the Director of Clinical Operations she said that nursing staff on Sundays were responsible to ensure that all oxygen tubing and filters were changed per doctor's orders. She said she expected her nursing staff to change residents' oxygen tubing and clean or replace their filters. She said that residents could be placed at risk of infection if they did not have their concentrator tubing and filters clean. During an interview on 2/25/26 at 10:00 a.m. the Executive Director of Operations said that she expected that nursing staff would keep residents' oxygen filters and tubing clean and replaced as ordered. She said that residents could be placed at risk for a respiratory infection if their oxygen tubing and filters were not clean. 3. Record review of Resident #2's face sheet dated 2/23/2026 indicated the resident was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of acute on chronic systolic congestive heart failure (a serious condition where the heart's ability to pump blood efficiently is impaired over time, affecting the left ventricle), Chronic obstructive pulmonary (a progressive lung disease that makes it difficult to breathe, primarily caused to irritants), Diabetes (a chronic condition that occurs when the body cannot properly use blood sugar) and morbid obesity (a complex chronic disease with BMI of 40 or higher). Record review of Resident #2's MDS assessment, dated 12/22/2025, indicated she understood and was understood by others. Resident #2 had a BIMS score of 7 indicating she had severe cognitive (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment. The MDS also indicated Resident #2 had shortness of breath while lying flat and required oxygen. Record review of Resident #2's Care Plan undated indicated the Resident #2 was on oxygen therapy related to Chronic Obstructive Pulmonary disease. The interventions included monitoring signs and symptoms of respiratory distress and report to MD as needed. The interventions also included oxygen via nasal cannula per MD orders. Record review of Resident #2's Medication administration record dated 2/1/2026-2/28/2026 indicated orders to change oxygen tubing weekly every night shift on Sunday. There was documentation the tubing was last changed on 2/15/2026. During an observation and interview on 2/22/2026 at 11:23 AM, Resident #2 was sitting up in bed with oxygen on 3 liters with oxygen concentrator water dated 2/5/2026. Resident #2 said she was treated with dignity and respect and had her call light within reach. Resident indicated the tubing was changed weekly. During an observation on 2/22/2026 at 1:46 PM, Resident #2's oxygen concentrator reservoir was dated 2/5/2026 and had not been changed out. During an interview on 2/24/2026 at 10:19 AM LVN E said the nurses were responsible for changing out the water on the concentrator and CNAs could notify the nurse if the water was out on the concentrator. LVN E said the nursing staff changed out the water routinely on Sundays. LVN E said the staff date and time the water on the concentrator. LVN E said the residents could have dryness of nasal passages and nose bleeds if the water was not changed. During an interview on 2/24/2026 at 1:59 PM, CNA B said the nurses were responsible for changing out the water in the concentrator and the tubing. She did not know how often it was changed out. During an interview on 2/25/2026 at 9:49 AM, CNA C said she assisted residents with taking their oxygen on and off during a transfer. She said they would take oxygen off and cover it with a bag to keep it clean. She said she would notify the nurse if the water was not bubbling. CNA C said she did not know when the water needed to be changed out. She said she had observed dates and labels on them. CNA C said the nurse was responsible for ensuring the water and tubing were changed. During an interview on 2/25/2026 at 10:09 AM LVN H said the water concentration was supposed to be changed when the water gets low or every 6-7 days. She said some residents used oxygen as needed so they had to watch it if it got low. She said the concentrator water dated 2/5/2026 would be over due to be changed if observed on 2/22/2026. She said the nurses were responsible for changing the water out. She said the water could get stale and not smell right. During an interview on 2/25/2026 at 11:18 AM, the DCO said the water should be changed one time a week. The DCO said the nurse on the night shift was responsible for changing out weekly. The DCO said she would expect the water to be changed if the date was 2/5/2026. She said it could place the residents at risk of infection with the water not being changed. During an interview on 2/25/2026 at 12:02 PM, the EDO said she expected the nurses to change out the water for the concentrator. She said she did not know when it was supposed to be changed out. She said she was not sure what could happen but felt it could be an infection control issue. The DCO (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the nurse was responsible for changing out the water. Record review of facility policy titled, Oxygen Therapy dated 4/2021 revealed that the purpose of this policy was to, It is the policy of this community to ensure all oxygen administration is conducted in a safe manner.Change the reservoir, Oxygen Cannula and tubing every 7 days.Keep Oxygen cannula and tubing used PRN in a plastic bag when not in use.Wash filters from oxygen concentrators every 7 days in warm soapy water. Rinse and squeeze dry.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments for 3 of 23 residents reviewed for storage of drugs and biologicals (Resident #9, Resident #32, and Resident #30) and 2 of 4 medication carts (Medication Cart #2 and Treatment Cart #4) reviewed for medication storage. The facility failed to securely store wound care chemicals for Resident #9.The facility failed to securely store fluticasone propionate nasal spray 50 micro grams (a corticosteroid used to relieve seasonal and year-round allergy symptoms, including nasal congestion, runny nose, itchy nose, sneezing, and watery eyes), fluticasone propionate and Salmeterol powder 250/50 micrograms (a combination prescription inhaler containing a corticosteroid and a long-acting beta-agonist), and povidone-iodine 10% solution (a fast-acting, broad-spectrum topical antiseptic used to prevent infections in minor cuts, scrapes, and burns, as well as for preoperative skin preparation) for Resident #32.The facility failed to keep over the counter supplements, Magnesium 200 mg, men's multivitamin secure for Resident #30.The facility failed to ensure Medication Cart #2 was locked when unattended.The facility failed to ensure Treatment Cart #4 was locked when unattended.This failure could place residents at risk for adverse reactions, risk of having access to unauthorized medication and/or lead to harm or drug diversions. Findings included: 1. Record review of Resident #9's face sheet, dated 11/23/23 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses that included Paraplegia (impairment or loss of motor and sensory function in the lower extremities and sometimes the torso, resulting from spinal cord damage in the thoracic, lumbar, or sacral regions), Muscle Wasting and Atrophy (involve the loss of muscle tissue and strength, typically caused by inactivity, malnutrition, aging (sarcopenia), or diseases affecting nerves or muscles), and Depression (a serious, common mood disorder causing persistent sadness, loss of interest, and functional impairment, affecting how you think, feel, and behave). Record review of Resident #9's quarterly MDS assessment, dated 02/03/26, revealed Resident #9 had a BIMS score of 10, which indicated moderately impaired cognition. Shows that Resident #9 was dependent for activities of daily living. Record review of Resident #9's care plan dated 2/05/26 shows that Resident #9 had an activities for daily living self-care deficit. Resident #9 required assistance with most all of her activities of daily living. During an interview and observation on 2/22/26 at 10:30 a.m. a bottle of wound care cleanser was left at Resident #9 bedside table. Resident #9 said that she did not know what was in the green spray bottle the surveyor found. She said that someone must have left it in her room. During an interview on 2/22/2026 at 10:46 a.m. LVN H said that she did not know that there were chemical products being left in resident rooms. She said that she would go get the wound care treatment chemicals. She said that these types of chemicals should be in the treatment cart or stored on the medication cart. She said that residents could be placed at risk of harm if they misused a chemical. She said that they could go blind or burn their throats. 2. Record review of Resident #32's face sheet, dated 02/17/26 revealed a [AGE] year-old female (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted on [DATE] and readmitted on [DATE] with diagnoses that included Respiratory Failure with Hypoxia (Respiratory failure is a critical condition where the lungs cannot adequately oxygenate the blood), Venous Insufficiency (occurs when leg vein valves become weak or damaged, causing blood to pool (venous reflux) rather than flowing back to the heart), Acute Pulmonary Edema (a life-threatening, sudden buildup of fluid in the lungs' air sacs, usually caused by rapid heart failure (cardiogenic) or lung injury). Record review of Resident #32's quarterly MDS assessment, dated 01/15/26, revealed Resident #32 had a BIMS score of 13, which indicated Resident #32 was cognitively intact. Shows that Resident #32 was dependent for most of her activities of daily living. Record review of Resident #32's care plan dated 10/24/25 shows that Resident #32 had an activities for daily living self-care deficit. Resident #32 required assistance with most all of her activities of daily living related to her disease process. During an interview and observation on 2/22/26 at 11:18 a.m. with Resident #32 it was observed that she had two bottles of fluticasone propionate nasal spray 50 micro grams (a corticosteroid used to relieve seasonal and year-round allergy symptoms, including nasal congestion, runny nose, itchy nose, sneezing, and watery eyes), fluticasone propionate and Salmeterol powder 250/50 micrograms (a combination prescription inhaler containing a corticosteroid and a long-acting beta-agonist), and povidone-iodine 10% solution (a fast-acting, broad-spectrum topical antiseptic used to prevent infections in minor cuts, scrapes, and burns, as well as for preoperative skin preparation.) She said that they were her medications that staff left with her. During an interview on 2/25/26 at 9:30 a.m. the Director of Nurses said that every staff in the facility was responsible to ensure residents did not have prohibited items in their rooms such as over the counter medications, chemicals, or wound care chemicals. She said that these items should be removed and then reported to her. She said that residents could be placed at risk of harm if they misused one of these items. During an interview on 2/25/26 at 10:00 a.m. the Administrator said that she expected that medications and chemicals were not left in residents' rooms. She said that they should be stored properly in the medication cart or medication room. She said that everyone was responsible to ensure that these items were not in residents' rooms. She said that residents could be placed at risk of harm if they did not use a medication or chemical properly. During an observation and interview on 2/22/2026 at 9:40 AM, revealed Treatment Cart #4 was unlocked and unattended with no nurse or medication aide at cart for 2 minutes. RN F said she left the treatment cart unlocked while she went to get a drink. RN F said she should not have left it unlocked. Observed a housekeeper and another resident in hallway where unlocked treatment cart was left unattended. During an observation and interview on 2/22/2026 at 12:07 PM - Observed medication cart #2 located near nurses' station on hall 200 unlocked. No staff near or within eye site of the unlocked medication cart. The drawers pulled out. RN G said the medication cart should only be unlocked when she was at the cart. She said she went to administer noon medication to a resident. She said leaving her medication cart unlocked could be a danger. She said a resident could take wrong medications. She said she was away from her medication cart for approximately 3 minutes. She said normally the facility had MAs administering medications. She said the DCO; Treatment nurse and herself were (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for ensuring medication carts were locked. Observed OTC medications in top drawer, Blister packets with resident medications in drawer 2. Side drawers observed liquid medications, narcotic box was securely locked inside medication cart #2. During an interview on 2/24/2026 at 10:19 AM, LVN E said a medication cart can be unlocked when in use and within sight. LVN E said the person who had access to the keys was responsible, nurses and medication aids. LVN E said medication carts were not shared during a shift. LVN E said someone could get in the medication cart such as a resident or visitor and take something not prescribed to them. She said it could make them sick. During an interview on 2/24/2026 at 1:59 PM CNA B said she would tell the charge nurse or the DCO if she observed a medication cart or the treatment cart unlocked. CNA said anyone could get in the medication or treatment cart. It could kill a resident or visitor if they took medication not prescribed. During an interview on 2/25/2026 9:49 AM CNA C said treatment carts and medication carts should not be unlocked. She said she had observed them unlocked but not all the time. CNA C said she had seen the wound care cart unlocked. CNA C said if a cart were unlocked, a resident who wanders could get in the medication cart, take the wrong medication. CNA C said anyone could get in the medications. She said it does not give them the right but gives them access. CNA C said the nurse who was assigned to the keys to the cart was responsible for ensuring it was locked. During an interview on 2/25/2026 at 10:09 AM LVN H said the nurses and MAs were responsible for ensuring the medication carts were locked. She said the medication carts should be locked when not at the medication cart. LVN H said a resident with dementia could get in the cart and take something that could harm them. LVN H said the treatment cart should be locked due to wound cleansers on the cart. During an interview on 2/25/2026 at 11:18 AM, the DCO said she expected the nursing staff and MAs to keep medication carts locked. She said the medication cart should only be unlocked when the nurses were directly in front of the medication or treatment cart. The DCO said a resident or visitor could take something out of the medication cart that could harm them. The DCO said a resident or visitor could take extra medications, or overdose. She said she did not think anyone could get to the narcotic box. The DCO said a resident could take medication that could cause side effects. She said the nurses and the treatment nurse were responsible for ensuring the medication carts were locked and secure. During an interview on 2/25/2026 at 11:57 AM, the EDO said she expected the medication and treatment carts to be locked. The EDO said it could only be unlocked when in use and getting medications for residents. The EDO said a resident or visitor could take medications that were not prescribed. The EDO said it could cause a person's blood pressure to drop, or adverse effect on the person. She said the person who had access to keys and who was assigned to the medication cart was responsible. Review of a facility policy titled Administering Medications last revised in April 2019 indicated .Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation.1. Only persons licensed or permitted by this state to prepare, administer and document.2. The Director of Nursing Services supervises and directs all personnel who administer medication.19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

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Focused Care of Gilmer	623 Hwy 155n Gilmer, TX 75644

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews 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 in that:1. The facility failed to dispose of expired prepackaged green onions that were actively decomposing.2. The facility failed to label and date bread, butter, and baked items.These deficient practices could place residents who received meals from the kitchen at risk for food borne illness.The findings were:During an observation of the kitchen on 2/22/26 at 10:01 a.m. it was observed that bread was not dated or labeled sitting on top of a toaster. Bags of green onion were expired, dated 1/17/2026, and unlabeled. [NAME] onions were decomposing inside of the bag releasing black liquid. Blocks of margarine were undated and labeled with no expiration date listed on the packaging.During an interview on 2/25/26 at 9:13 a.m. with the Dietary Manager she stated that food should be labeled and dated. She said that food should be covered properly. She stated that food that was expired or actively decomposing in the refrigerator should have been thrown away. She said that all kitchen staff were responsible to ensure that all regulations were followed. She said that residents could be placed at risk for foodborne illness if they consumed expired food or food that was not stored properly.During an interview on 2/25/26 at 9:30 a.m. with the Director of Clinical Operations she said that she expected that kitchen staff follow regulations to prevent foodborne illness. She stated that residents could be placed at risk for foodborne illness if they ate food that was not properly handled. She said that residents in nursing homes could be more vulnerable to food that was not handled properly.During an interview on 2/25/26 at 10:00 a.m. the Executive Director of Operations said that she expects that food in the kitchen will be stored properly, labeled, dated, and expired food thrown away. She said that residents could have been placed at risk of foodborne illness if they ate food that was contaminated or not handled properly. Record review of a facility policy titled, Food Storage dated 2/2026 revealed the purpose of this policy was, Food should be stored in a safe and sanitary method to prevent contamination and food-borne illness. All food should be stored according to local, state, and federal regulations.Bulk items that have been opened should be stored in covered containers or sealed bags and should be labeled and dated. Items should be sealed, labeled and dated. Use the first-in, first-out rotation method. Date packages and new items should be placed behind existing ones, so that the older items are used first.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 16 residents (Resident # 17, Resident #52, and Resident #69) reviewed for resident rights.1. The facility failed to ensure Resident #17 was able to access her bedroom furnishings.2. The facility failed to ensure Resident #69 was able to access her call light.This failure could place residents at risk for unmet needs and decreased quality of life.Findings include:1. Record review of Resident #17's face sheet, dated 08/21/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included Paraplegia (impairment or loss of motor and sensory function in the lower extremities and sometimes the torso, resulting from spinal cord damage in the thoracic, lumbar, or sacral regions), Muscle Wasting and Atrophy (involve the loss of muscle tissue and strength, typically caused by inactivity, malnutrition, aging [sarcopenia], or diseases affecting nerves or muscles), Needs for Assistance with Personal Care (mobility, hygiene, and daily living tasks to maintain dignity, safety, and independence at home).Record review of Resident #17's quarterly MDS assessment, dated 12/15/25, reflected Resident #17 had a BIMS of 09, which indicated moderately impaired cognition. Resident #17 was dependent for activities of daily living.Record review of Resident #17's care plan, dated 2/19/26, reflected Resident #17 had an activities for daily living self-care deficit. Resident #17 required assistance with most all of her activities of daily living.During an observation and interview on 02/22/26 at 10:30 a.m., Resident #17 said she stored a lot of her snacks in her bed because staff won't turn her bed the other direction so she could reach her nightstand. She said her nightstand was at the foot of her bed and she could not move herself that far. It was observed that Resident #17 had a trapeze bar to pull herself up as she had limited mobility. There were multiple jars of protein powder, peanut butter and other snack items laying in her bed. Her nightstand was at the foot of her bed and she was unable to reach. She said she used a hoyer lift to get out of bed. She said she asked staff multiple times to change the direction of her bed so she could make use of her nightstand, but they told her okay and then nothing happened.During an observation and interview on 02/23/2026 at 2:20 p.m., Resident #17's nightstand was not in a position to reach. She said the items on her nightstand, her snacks, were out of reach and she had to wait for the staff to come into her room to help her get them.During an interview on 2/25/26 at 9:30 a.m., the Director of Nurses said residents who were dependent for care should have their needs met which included being able to reach their bedside nightstands or bedside tables. She said if a resident's needs were not being met all staff should report to her so the issue could be fixed. She said a resident could suffer a lower quality of life if their needs were not met.During an interview on 2/25/26 at 10:00 a.m., the Administrator said she expected all staff to ensure residents' needs were being met. She said she expected that if a resident had a specific need that wasn't being met it should be reported so the residents did not have a lower quality of life. She said a resident could have a lower quality of life if they were unable to reach their bedside nightstand to store their belongings.2. Record review of Resident #69's face sheet, dated 02/25/2026, indicated Resident #69 was [AGE] year-old female who was admitted to the facility on [DATE]. Resident #69 had diagnoses which included Vascular dementia (a type of dementia that occurs when the brain's blood vessels are damaged or blocked, disrupting the supply of oxygen and nutrients to brain cells), Type II Diabetes (a chronic condition that occurs when the body cannot properly use blood sugar), morbid obesity (a complex chronic disease with BMI of 40 or higher) and bipolar disorder (a mental condition characterized by significant mood swings). Record review of Resident #69's MDS, dated [DATE], indicated Resident #69 was understood and understood others. The Resident #69 had a BIMS score of 11, which indicated moderate cognitive impairment. Resident #69 required substantial/maximal assistance with (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADLs.Record review of Resident #69's, undated, care plan indicated Resident #69 was at risk of falling related to history of falls, Physical impairment, and Right Below the knee amputation. Interventions included anticipating needs, provide assistance and ensuring call light was in reach and answered promptly.During an observation and interview on 2/22/2026 at 10:23 AM, Resident #69 said she was sick to her stomach and needed some medication for nausea. The resident's call light was on the floor and out of the resident's reach and she was unable to reach staff for medication. The State Surveyor notified RN G of resident complaints of nausea.During an interview on 2/24/2026 at 10:19 AM, LVN G said call lights should be placed within reach so the residents could use it. LVN G said the resident would not be able to receive the care, if they needed help. LVN G said it was everyone's responsibility for ensuring call lights were within reach. She said 2-3 minutes was a reasonable time for a call light to be answered. LVN G said it was important to at least check in and notify the residents when you would be back in. LVN G said a resident may need a drink or need to go to the bathroom. She said a resident could fall or hurt themselves if they did not have access to their call light.During an interview on 2/24/2026 at 1:59 PM, CNA B said call lights should be placed next to the resident. She said the CNAs and all staff were responsible for ensuring the residents call lights were within reach. CNA B said the call light was the resident's lifeline. She said the residents would not be able to reach anyone for help or their needs may not be met. CNA B said the residents may need water or need their brief change and try to get up and fall.During an interview on 2/25/2026 at 9:46 AM, CNA C said the CNAs were responsible for ensuring the call lights were within reach. She said a resident could fall if they were unable to get up independently. She said the call light should be placed on the bed, wheelchair or on a pillowcase so the resident could reach it no matter where the resident was sitting.During an interview on 2/25/2026 at 10:09 AM, LVN H said the staff were responsible for ensuring the call lights were within resident's reach. She said the staff placed the call light where the resident could see and reach it. LVN H said it should not be draped over the light or anything else out of reach. LVN H said CNAs and Nurses made rounds and made sure the residents were doing okay and call lights were within reach. She said a resident could try to reach for the call light and fall out of bed. She said some residents had respiratory problems and they need to make sure the call light was within reach or a resident could fall resulting in an injury.During an interview on 2/25/2026 at 11:18 AM, the DCO said she expected the nurse and CNA, or any staff who got in the resident room to ensure the call light was within the reach of the residents and clipped to their bedsheet. She said it placed the residents at risk of not getting needs met if not in reach. The DCO said a resident could fall causing an injury.During an interview on 2/25/2026 at 11:55 AM, the EDO said she expected the resident call lights to be placed within the residents reach. The EDO said the nurse and care staff were responsible for ensuring call lights were within reach. The EDO said a resident may not be able to call for help and the staff may not meet their needs.Record review of the facility's policy and procedure Quality of Life- Accommodation of Needs dated August 2009, indicated . Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being. The residents' individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. A. providing access to assistive devices, such as grab bars in the bathroom; B. arranging furniture as the resident requests, providing the arrangement is safe, his or her roommate agrees and space allows.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident had the right to be free from misappropriation of property and exploitation for 1 of 4 residents (Resident #3) reviewed for misappropriation of property. The facility failed to prevent the misappropriation of Resident #3's Hydrocodone (Norco) (a combination medicine that is commonly taken for severe pain). This failure could place residents at risk for uncontrolled pain. Record review of Resident #3's face sheet, dated 2/24/2026, indicated Resident #3 was an [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #3 had diagnoses which included chronic venous hypertension with ulcers to bilateral lower extremities (occurs when veins in the lower extremities fail to efficiently return blood to the heart), Sepsis (a life-threatening condition caused by the body's extreme response to an infection), diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy), and lymphedema (a condition characterized by swelling caused by an accumulation of protein-rich fluid in the body's tissues, primarily affecting the arms or legs).Record review of Resident #3's quarterly MDS, dated [DATE], indicated he was usually able to make self-understood and usually understood others. Resident #3 had a BIMS score of 6, which indicated he had severe cognitive impairment. Resident #3 was dependent on toileting and bathing, required moderate assistance with personal hygiene, and dressing lower body.Record review of Resident #3's, undated, care plan indicated Resident #3 had potential for pain and risk for injury from decrease in activities of daily living and was currently on hospice care. Interventions included:Assess characteristics of pain: location, severity, on a scale of 1-10, type and frequency.Discuss with resident factors precipitated pain and what may reduce it.Administer medication as ordered.Discuss with resident the need to request pain medications before pain becomes severe.Discuss with physician that maximum pain relief pain medication were best given around the clock, with PRNs for breakthrough pain.Monitor for potential side effects of pain medication.Record review of Resident #3's Medication Administration record, dated 2/1/2026-2/28/2026, indicated he was prescribed Hydrocodone-Acetaminophen 7.5-325 mg 1 tablet by mouth one tablet every 4 hours as needed for pain.Record review of the pharmacy narcotic sheet, dated 2/7/2026 at 2:47 AM, indicated Hydrocodone-Acetaminophen 7.5-325 mg was delivered with 55 tablets filled and received on 2/7/2026 at 1:39 AM. Resident #3 received Hydrocodone 7.5-325 mg on 2/2/2026 and 2/9/2026.Record review of Resident #3's pain assessment, dated 2/17/2026, indicated pain level 2 out of 10 related pain to right and left lower leg wounds. Resident #3 refused pain medication at the time of the assessment.Record review of the facility's Provider Investigation Report of the misappropriation of medication, dated 2/18/2026, the facility initiated an investigation into the missing medication for Resident #3. The investigation report indicated the facility assessed Resident #3 for pain, staff were in-serviced initiated on drug diversion, how to count narcotics, process of completion of narcotic and where sheets go and safe surveys initiated for drug diversion. The facility provided drug screens for 6 nurses who worked shifts and the SW assessed Resident #3 for mental distress and no distress noted. Provider post-investigation was Unconfirmed. Resident #3 was noted to be happy and received medications as requested and no doses were missed.During an interview on 2/22/2026 at 11:15 AM, Resident #3 said everything was going good. Resident #3 said he was treated with dignity and respect. The resident said he had pain and received his pain medication timely. The resident was unable to recall a time when he received medication and pain not relieved. Resident #3 had no concerns with his care.During an interview on 2/23/2026 at 8:11 AM, CMA J said she was responsible for administering medication on Halls 100,200, and 400. She said she completed narcotic counts at every shift change. CMA J said she observed counts being off count, but it was because the nurse did not sign off. She said the nursing staff counts the cards and one stands by the book to ensure the medication counts match. CMA J said the staff could not locate the narcotic card for (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were to initiate card count sheet and stop making copies of the sheets. She said the facility used the count sheet the medications come in with. The DCO said she was responsible for all medications in the building.During an interview on 2/25/2026 at 12:03 PM, the EDO said the facility had not come to a conclusion with their investigation. She said 6 nurses had been drug tested and 4 were negative. She said 1 had to retest due to running a fever and the other nurse did not have transportation to the testing facility. The staff had not completed the drug test prior to end of survey. The EDO said the facility had in-services with staff regarding the counts, processes on completion of medications and where the sheets were to go. The EDO said she expected the narcotic counts to be accurate and medications were secured. She said she expected all the cards to be accounted for and reported immediately if any counts were off. The EDO said the nurses assigned to the medication cart with the keys were responsible for ensuring the medications were secured.During an interview following a return call on 2/25/2026 at 2:32 PM, LVN M said she worked the night shift and did not recall receiving the medication for Resident #3. She said she would administer Resident #3's Hydrocodone prior to performing his wound care. She said she did not recall if she received his medication when it came in. She said if the nurse for the resident was at the facility, she would have handed it off to the nurse who worked on Hall 200. She said the staff were in-serviced and they now had a process in place for two people to sign off when the medication was received. She said she never had narcotic counts off in the past.Record review of the facility's policy, revised 8-2020, titled Discrepancies, Loss, and/or Diversion of Medication indicated Policy.all discrepancies, suspected loss, and/or diversion of medications, irrespective of drug type or class, are immediately investigated and a report filed. Procedures.Immediately upon discovery or suspicion of a discrepancy, suspected loss of diversion, the ADM, DON and consultant pharmacist are notified and investigation conducted.I. Discrepancy on a drug count.The DON investigates the discrepancy and researches al the records related to medication administration and the supply.Medication reconciliation is made from the last known date and time of reconciliation.A thorough search is conducted in all drug storage areas, the resident room, and any locations where medications may have been used or placed during medication administration.If the discrepancy cannot be reconciled after a thorough investigation has be completed the remaining supply is documented with the current date and the accountability process restarted.The medication in question should be checked several times.Appropriate agencies required by state regulation will be notified. II Loss of supply of medication.The DON investigates the suspected loss and research all the records related to medication receipt, its use since receipt, and all persons involved with medication administration and supply of medication and identifies the last known point in time that medication was available. The pharmacy should be notified, and the pharmacy should verify the medication was dispensed.4. If the loss invoices a controlled substance, all the controlled drug accountability procedures and document should be reviewed and audited. If the audit reveals a particular individual or individuals who might be suspected of involvement of loss, appropriate disciplinary actions are taken and deferred to human resource policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 residents (Resident #35) reviewed for care plans. The facility failed to implement the comprehensive person-centered care plan for Resident #35 by not documenting resident's need for oxygen therapy. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services Findings include:Record review of Resident #35's face sheet, dated 12/28/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which included Acute and Chronic Respiratory Failure with Hypercapnia (occurs when a patient with underlying chronic respiratory insufficiency suffers a sudden, severe decline in lung function, often due to an infection or exacerbation), Acute Pulmonary Edema (a life-threatening, sudden buildup of fluid in the lungs' air sacs, usually caused by rapid heart failure [cardiogenic] or lung injury), and Cognitive Communication Deficit (difficulties with verbal and non-verbal communication caused by underlying impairments in thinking skills-such as memory, attention, organization, and reasoning-rather than primary language disorders).Record review of Resident #35's quarterly MDS assessment, dated 1/27/26, reflected Resident #35 had a BIMS of 03, which indicated severely impaired cognition. Resident #35 required oxygen therapy on admission and while a resident.Record review of Resident #35's care plan dated 1/23/26 reflected a lack of care planning regarding oxygen therapy. There was no information entered into the care plan regarding oxygen therapy. Record review of an order for Resident #35, dated 10/21/25, reflected an order was placed for, Oxygen at 2 liters per nasal cannula to maintain peripheral capillary oxygen saturation greater than 90%During an interview on 2/25/26 at 9:30 a.m. the Director of Nurses said oxygen therapy should be on a resident's care plan. She said she was responsible to ensure care plan's were accurate and all resident care was documented on their care plan. She said residents could be placed at risk of not receiving oxygen therapy if their oxygen order was not care planned. She said that a resident could not have oxygen therapy if it was not documented in their care plan.During an interview on 2/25/26 at 10:00 a.m., the Administrator said she expected care plans were accurate and reflected the needs of each resident. She said if a resident received oxygen therapy it should be documented on their care plan. She said residents could be placed at risk of not receiving their oxygen therapy if it was not properly care planned.Record review of the facility's policy titled, Resident Assessment, dated 1/20/2021, reflected, Every resident will have an individualized interdisciplinary plan of care in place. A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of Admission. The Interdisciplinary Team will continue to develop the plan in conjunction with the Resident Assessment Instrument, completing and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process. The resident's Care Plan will include participation from residents' representatives, external partners Preadmission Screening and Resident Review, Hospice, Therapy, Clinicians and not as all-inclusive.A Registered Nurse will complete the Baseline Care Plan in the RN's absence in the Clinical reimbursement role. An Registered Nurse initiates all Care Plans.

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Focused Care of Gilmer	623 Hwy 155n Gilmer, TX 75644

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 5 residents (Resident #16 and Resident 64) reviewed for skin integrity. The facility failed to ensure Resident #16 and Resident 64's pressure- redistribution mattress (is designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) was on the correct settings. This failure could place residents at risk for developing pressure ulcers and could contribute to developing avoidable pressure ulcers. Findings include: 1.Record review of Resident #16's face sheet, dated 2/24/26, indicated a [AGE] year-old male initially admitted to the facility on [DATE]. Resident #16 had diagnoses which included cellulitis of buttocks (a bacterial infection of the deep skin layers), morbid (serve) obesity due to excess calories, body mass index (BMI) 60.0-69.9 adult and pressure ulcer of sacral region, unstageable. Record review of Resident #16's quarterly MDS assessment, dated 2/10/26, indicated Resident #16 was understood and understood by others. Resident #16's BIMS score of 15, which indicated cognition was intact. Resident #16 was dependent with ADLs. Resident #16 weighed 409 pounds. Resident #16 was at risk of pressure ulcer/injuries. Resident #16 received a pressure reducing device for bed. Record review of Resident #16's care plan, dated 1/27/26, indicated Resident #16 had unstageable pressure injury to the sacral area due to immobility. Interventions included administer treatments as ordered and monitor for effectiveness. Record review of Resident #16's physicians order, dated 8/28/25 , indicated may have pressure redistribution mattress. Record review of Resident #16's weight record, dated 2/23/26, indicated:*2/2/26 - 344.6 pounds*1/11/26 - 340.0 pounds*12/12/25 - 367.0 pounds During an observation on 2/22/26 at 12:58 P.M., revealed Resident #16 was lying in bed eating lunch. Resident #16's pressure redistribution mattress weight setting was 430 pounds. During an observation on 2/23/26 at 12:05 P.M., revealed Resident #16 was lying in bed watching television. Resident #16's pressure redistribution mattress weight setting was 430 pounds. During an observation on 2/24/26 at 9:51 A.M., revealed Resident #16 was lying in bed asleep. Resident #16's pressure redistribution mattress weight setting was 430 pounds. 2. Record review of Resident #64's care plan, dated 7/25/25, indicated Resident #64 had current skin concerns. Right proximal knee wound. Interventions included monitor areas for increase breakdown signs and symptoms of infection and report to the medical director. Record review of Resident #64 face sheet, dated 2/24/26, indicated a 59-years-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #64 had diagnoses which included local infections of the skin and subcutaneous tissue (microbial invasions) and morbid (serve) obesity due to excess calories and abnormal posture. Record review of Resident #64's quarterly MDS assessment, dated 1/16/26, indicated Resident #64 was understood and understood by others. Resident #64's had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #64 was dependent with ADLs. Resident #64 weighed 334 pounds. Resident #64 was at risk of pressure ulcer/injuries. Resident #64 received a pressure reducing device for bed. Record review of Resident #64's physicians order, dated 10/28/25, indicated may have pressure redistribution mattress. During an observation on 2/22/26 at 1:18 P.M., revealed Resident #64 was lying in bed resting. Resident #64's pressure redistribution mattress weight setting was 430 pounds. During an observation on 2/23/26 at 12:07 P.M., revealed Resident #64 was lying in bed asleep. Resident #64's pressure redistribution mattress weight setting was 430 pounds. During an observation on 2/24/26 at 9:52 A.M., revealed Resident #64 was lying in bed asleep. Resident #64's pressure redistribution mattress weight setting was 430 pounds. During observation and interview on 2/24/26 at 2:26 P.M., RN D said she expected the resident's bed to be set appropriately to their weights. She said Resident #16 and Resident #64's beds were not set to the resident's weights. She said the nurses were responsible for ensuring the beds (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were set to the resident's weight. She said the risk of not having the redistribution mattress set at the correct setting was pressure and it could cause wounds. During an interview on 2/24/26 at 3:00 P.M., LVN A said she knew Resident #16 and Resident #64 had weight loss and they both complained about feeling like they were laying on the bars of the bed frame and asked for the mattress to be increased. She said she expected redistribution beds to be in the correct setting according to the resident's weight. She said everyone was responsible for ensuring the residents' redistribution mattress beds were on the correct setting. She said the risk was pressure injury. During an interview on 2/25/26 at 10:33 A.M., the Director of Clinical Operations said she expected the residents to have their beds set to the correct setting. She said the nurses were responsible for ensuring the beds were set correctly. She said the risk was the bed was being ineffective. During an interview on 2/25/26 at 10:55 A.M., the Executive Director of Operations said she expected the resident's redistribution beds to be set in the correct setting. She said the nurses were responsible for ensuring the settings were set for the pressure redistribution mattress. She said the risk was wounds worsening and not healing like they should. Record review of the facility's Skin Management: Prevention and Treatment of Wounds policy, revised 11/01/2019, 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. 2. Prevention: Residents at risk for developing pressure injuries will have pressure reduction cushion devices in their wheelchair and pressure reduction mattress on bed. 4. Treatment: Specialty mattress will be implemented for resident with multiple stage ll areas, stage lll, or stage lV pressure injuries. Mattress settings will be used according to manufacturer's guidelines.

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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 had an indwelling catheter with a drainage bag had a securing device for 1 of 5 residents (Resident #18) reviewed for catheter care. The facility failed to ensure Resident #18's indwelling foley catheter (drains urine from your urinary bladder into a bag outside your body) had a catheter securement device to anchor the catheter to her leg. This failure could place residents at risk for friction, pulling, pain and trauma.Findings included: Record review of Resident #18's face sheet dated 2/23/26 reflected a [AGE] year-old female who was initially admitted on [DATE] and was readmitted to the facility on [DATE]. Resident #18 had diagnoses which included: neuromuscular dysfunction of the bladder (the loss of normal bladder control due to nerve damage), retention of urine (the inability to fully empty the bladder) and need for assistance with personal care. Record review of Resident #18's MDS assessment, dated 2/20/26, reflected Resident #18 was usually understood and usually understood by others. Resident #18's BIMS score was a 4, which indicated severely impaired cognition. Resident #18 required maximal assistance with ADLs. Resident #18 was occasionally incontinent to bowel and had a catheter for urinary continence. Record review of Resident #18's care plan dated 1/23/26 reflected Resident #18 had an indwelling foley catheter as evidence by: neuromuscular dysfunction of bladder and was at risk for increased urinary tract infection. The intervention included check tubing for kinks each shift. Record review of Resident #18's order summary report reflected, check foley catheter placement, ensure foley is secured via securing device to reduce friction/ pulling every shift, dated 7/3/25. During an observation on 2/23/26 at 1:56 PM, CNA B provided incontinent care on Resident #18. Resident #18 had a foley catheter. Prior to the care Resident #18 did not have a catheter securement device in place. During an interview on 2/23/26 at 2:10 PM, CNA B said Resident #18 should always have a catheter securement device in place. She said she was not sure why the resident did not have a catheter securement device in place, because she usually had one. She said the nurse was responsible for putting the securement device on, but she said she would let the nurse know Resident #18 did not have one. She said the risk of her not having a securement device was that the catheter could get pulled and cause injury. During an interview on 2/24/26 at 2:26 PM, RN D said Resident #18 was supposed to have a catheter securement device in place. She said she expected all residents to have a securement device for the catheters. She said the nurse was responsible for ensuring the residents have the securement device in place. She said normally, the CNA's let the nurse know if the securement device came off. She said the risk of not having a securement device in place on a resident with a catheter was it could get pulled and cause an injury. During an interview on 2/25/26 at 10:33 AM, the Director of Clinical Operations said Resident #18 should have a catheter securement device in place. She said she expected every resident that has a catheter to have a securement device. She said the nurses were responsible for ensuring the residents had a securement device. She said the risk was trauma and pain. During an interview on 2/25/26 at 10:37 AM, the Executive Director of Operations said she expected the resident to have a catheter securement device in place. She said the catheter could have been pulled out. She said the risk to the resident was pain and a possible infection. Record review of the facility's, Catheters-Insertion and Care: Indwelling, Straight, Supra-Pubic, and External, dated 04/2021 stated: It is the policy of this community that the resident with a urinary catheter will be provided service in a safe and appropriate manner to minimize the risks of urinary tract complications. 4. Tape or catheter strap. 7. Attach catheter strap to leg to assist in securing tubing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and to help prevent the development and transmission of communicable diseases and infections for 2 of 16 residents (Resident #18 and Resident #36) reviewed for infection control practices. 1. The facility failed to ensure CNA B removed her gown when she entered the hallway to get gloves while providing incontinent care and catheter care for Resident #18 on enhanced barrier precautions on 2/22/26. 2. The facility failed to ensure Resident #36's feeding tubing port was capped and off the floor. These failures could place residents at risk for cross contamination and the spread of infection. Findings include: Record review of Resident #18's face sheet dated 2/23/26 reflected a [AGE] year-old female who was initially admitted on [DATE] and was readmitted to the facility on [DATE]. Resident #18 had diagnoses which included: neuromuscular dysfunction of the bladder (the loss of normal bladder control due to nerve damage), retention of urine (the inability to fully empty the bladder) and need for assistance with personal care. Record review of Resident #18's MDS assessment, dated 2/20/26, reflected Resident #18 was usually understood and usually understood by others. Resident #18's BIMS score was a 4, which indicated severe impaired cognition. Resident #18 required maximal assistance with ADLs. Resident #18 was occasionally incontinent of bowel and had a catheter for urinary continence. Record review of Resident #18's care plan dated 1/28/26 reflected Resident #18 was on EBP for an indwelling catheter. The interventions: EBP supplies (gown and gloves) will be readily available, EBP supplies will be discarded in regular trash receptacle unless soiled with blood or bodily fluids and staff will maintain EBP during high contact resident care activities such as dressing, bathing/ showering, transferring, providing hygiene, changing linen, changing briefs or toileting. Record review of Resident #18's care plan dated 1/23/26 reflected Resident #18 had an indwelling foley catheter as evidence by: neuromuscular dysfunction of bladder and was at risk for increased urinary tract infection. The intervention included check tubing for kinks each shift. Record review of Resident #18's order summary report reflected, check foley catheter placement, ensure foley was secured via securing device to reduce friction/ pulling every shift, dated 7/3/25. Implement EBP (use of gown and gloves) with all high contact resident care, every shift for indwelling catheter, dated 7/3/25. During an observation on 2/23/26 at 1:56 P.M., CNA B performed incontinent care on Resident #18 and left resident's room while performing incontinent care to get gloves while gown was on for EBP. During an observation on 2/23/26 at 2:03 P.M., CNA B returned to Resident #18's room and performed catheter care on the resident with the gown on she wore in the hallway while getting gloves. During an interview on 2/23/26 at 2:10 P.M., CNA B said she knew she should have taken the gown off when she felt the resident's room to get gloves. She said the negative effect of wearing the gown in the hallway was cross contamination. During an interview on 2/24/26 at 2:26 P.M., RN D said she expected the CNAs to remove their PPE when leaving a resident's room on EBP. She said the staff wearing the PPE were responsible for following the EBP protocol by removing the PPE before leaving the resident's room. She said the risk was an infection; staff could contaminate the resident. Record review of Resident #36's face sheet dated 2/24/26 reflected a [AGE] year-old male who was initially admitted on [DATE] and was readmitted to the facility on [DATE]. Resident #36 had diagnoses which included: unspecified severe protein-calorie malnutrition (a critical condition indicating extreme nutrient deficiency), resistance to multiple antimycobacterial drugs (a severe global health threat defined by strains resisting key agents like isoniazid), dysphagia (difficulty swallowing), gastrostomy status (presence of an artificial opening in the stomach) and acute metabolic acidosis (a serious condition where excessive acid accumulates in body fluids). Record review of Resident #36's MDS assessment, dated 11/20/25, reflected Resident #36 was sometimes understood and sometimes understood by others. Resident #36 required maximal assistance with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADLs. Record review of Resident #36's care plan dated 2/18/26 reflected Resident #36 required tube feeding jevity 1.5 related to resisting eating, weight loss and malnutrition. The intervention was to monitor/ document/ report PRN any signs and symptoms of aspiration, fever, shortness of breath, tube dislodge and infection at tube site. Record review of Resident #36's order summary report reflected, enteral-feed order one time a day for supplement feeding Glucerna at 60 milliliters/hour times 20 hours and water at 45 milliliters/hour times 20 hours. Turn feeding pump off at 10:00 AM, and restart at 4:00 PM, to allow for 18 hours of down time; in the morning for downtime, downtime 10:00 AM-4:00 PM to total 18hours of runtime, dated 2/15/26. During an observation on 2/22/26 at 11:35 AM, Resident #36 was lying in bed resting. Resident #36's feeding and tubing hanging; feeding tubing port uncapped and opened to air. During an observation on 2/23/26 at 12:14 P.M., Resident #36 was lying in bed. Resident #36's feeding and tubing hanging; feeding tubing port uncapped and on floor. During an observation on 2/24/26 at 9:57 A.M., Resident #36 was lying in bed. Resident #36's feeding and tubing hanging; feeding tubing port uncapped and on floor. During an observation on 2/24/26 at 11:11 A.M., Resident #36 was lying in bed. Resident #36's feeding and tubing hanging; feeding tubing port uncapped and on floor. During an interview on 2/24/26 at 11:22 A.M., LVN E said the nurses were responsible for maintaining the feeding tubes of the residents. She said she expected the feeding tubing to be secured and off the floor. She said the resident was at risk of infection. She said it could have a negative impact on the residents if nurses hooked the tubing into his feeding port after it had been on the floor. During an interview on 2/25/26 at 10:33 A.M., the Director of Clinical Operations said she expected the nurses to prevent the feeding tube of the residents from contamination. The nurses were responsible for the residents' feeding tubes. She said she expected staff to remove their PPE prior to exiting a resident's room on EBP. She said staff members wearing PPE were responsible for removing their PPE. She said the risk was infection to the residents. During an interview on 2/25/26 at 10:55 A.M., the Executive Director of Operations said she expected the feeding tubes to be capped and not on floor. She said nurses were responsible for ensuring the tubing was capped and off the floor. She said she expected staff to remove their PPE prior to exiting a resident's room. She said the staff or whoever was wearing the PPE were responsible for removing the PPE, because they had been trained to do so. She said the risk of the feeding tubing port uncapped and on the floor was infection and the risk of not removing the gown was spreading infection throughout the facility. Record review of the facility's policy and procedures Infection Control dated 10/25/2022, indicated. This communities' infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.5. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. Record review of the facility's policy and procedure Enhanced Barrier Precautions dated 4/01/2024, indicated. Enhanced barrier precautions (EBPs) are a CDC guidance to reduce the transmission of multi-drug-resistant organisms (MDROs) in health care settings, including nursing homes. to residents. EBP require team members to wear gowns and gloves while performing high-contact care activities with residents who are infected or colonized with a targeted MDRO, or who have open wound or indwelling medical device.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents could 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 3 residents (Resident #52) reviewed for resident call system. The facility failed to ensure Resident #52 had a call light button attached to the call light system. Resident #52 did not have a call light available from 2/22/26 until 2/24/26. This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity. Findings include: Record review of Resident #52's face sheet, dated 2/23/26, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #52 had diagnoses which included: chronic systolic (congestive) heart failure (where the left ventricle weakens and cannot pump enough blood), chronic gout due to renal impairment (high uric acid levels leading to persistent urate crystal deposits in the joints and soft tissue), muscle wasting and atrophy (wasting, shrinking, or thinning of a body part), difficulty walking, muscle weakness, other abnormalities of gait and mobility, unspecified lack of coordination, history of falling. Record review of Resident #52's MDS assessment, dated 12/16/25, reflected Resident #52 was understood and understood by others. Resident #52's BIMS score was a 13, which indicated cognition was intact. Resident #52 required supervision assistance with all ADLs. Resident #52 was always incontinent to bowel and bladder.Record review of Resident #52's care plan, dated 7/23/20, reflected Resident #52 was a risk for increased falls and fractures as evidence by impaired mobility. The interventions included: anticipate needs, provide prompt assistance, encourage the resident to ask for assistance of staff, and ensure call light was in reach and answer promptly. During an observation on 2/22/26 at 11:34 A.M., Resident #52 was not in the room. Resident #52 did not have a call light button attached to the call light system. During an observation on 2/23/26 at 12:13 P.M., Resident #52 was not in the room. Resident #52 did not have a call light button attached to the call light system. During an observation on 2/24/26 at 9:56 A.M., Resident #52 was not in the room. Resident #52 did not have a call light button attached to the call light system. During an interview on 2/22/26 at 1:24 P.M., revealed Resident #52 was sitting up in a wheelchair in his room. Resident #52 did not have a call light button attached to the call light system. Resident #52 said no, he did not have a call light; he said he just noticed there was call light for his bed, but he did not use the call light, because he did not need assistance often. During an interview on 2/24/26 at 2:26 P.M., RN D said Resident #52 did not have a call light. She said she expected resident's call lights to be accessible for them. She said everyone was responsible for ensuring the call lights were assessable for the residents. She said the negative effect of not having a call light assessable for the residents was falls and any other needs could go unmet. During an interview on 2/24/26 at 2:52 P.M., CNA C said she noticed Resident #52 did not have a call light. She said CNAs were responsible for ensuring the resident's call lights were within reach. She said the Director of Plant Operation was responsible for replacing the call lights. She said a negative effect of not having the call lights accessible for a resident was he could fall. During an interview on 2/24/26 at 3:00 P.M., LVN A said she expected the residents' call lights to be within reach. She said everyone was responsible for ensuring the call lights were accessible. She said the negative effect of the call lights not being assessable was that the residents could fall, they could have an emergency, and they may need to be changed and could not get help. During an interview on 2/25/26 at 9:54 A.M., the Director of Plant Operations said he expected the residents to have call lights. He said the whole building as a whole was responsible for ensuring the residents had a call light. A risk was the potential of Resident #52 not being able to get contact with staff if needed. During an interview on 2/25/26 at 10:33 A.M., the Director of Clinical Operations said she expected residents to always have a call light within reach. She said any employee who entered the rooms was responsible for ensuring the residents' call lights were there and accessible. She said the negative (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effect of Resident #52 not having a call light was he could fall and not meet his needs. During an interview on 2/25/26 at 10:55 A.M., the Executive Director of Operations said she expected the call lights to be accessible to the residents. She said maintenance was responsible for ensuring the call light was in the residents' rooms. She said nurses and CNAs were responsible for ensuring the residents' call lights were assessable and they were responsible for letting maintenance know about missing call lights. She said the negative effect of not having the call light accessible was that the resident needs not met if he could call anyone. Record review of the facility's policy and procedure Quality of Life- Accommodation of Needs dated August 2009, indicated . Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being. The residents' individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. A. providing access to assistive devices, such as grab bars in the bathroom; B. arranging furniture as the resident requests, providing the arrangement is safe, his or her roommate agrees and space allows.