STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure each resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 6 residents (Resident #1) reviewed for self-determination.The facility failed to ensure Resident #1 was provided with showers during the day shift instead of showers at nighttime per Resident #1's family's request. This failure could place residents at risk of being denied the opportunity to exercise his or her own rights regarding the things that were important in their life and decrease their quality of life.Findings included:Record review of a face sheet, dated 02/11/2026, indicated Resident #1 was a [AGE] year-old female, admitted [DATE], re-admitted [DATE], with diagnoses including Alzheimer's early onset (a brain disease that slowly damages your memory, thinking, learning and organized skills), muscle weakness, abnormalities of gait and mobility, other lack of coordination, hypertension (high blood pressure). Record review of the Comprehensive MDS assessment, dated 01/29/2026, indicated Resident #1 was able to make herself understood and was understood by others. The MDS assessment indicated Resident #1 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #1 was dependent on staff for showering/bathing self. Record review of Resident #1's care plan reviewed 1/16/2026 indicated she had a self-care deficit and required assistance by staff for showering. Resident #1's care plan did not indicate her shower preferences. Record review of Resident #1's Shower Sheets Assignments, dated 02/02/2026 - 02/09/2026, indicated she was scheduled for showers on the 6 p.m.- 6 a.m. shift on Monday, Wednesday, and Friday. The Shower Sheets Assignments indicated on 02/02/2026 - 02/09/2026 Resident #1 received a bed bath between the hours of 10:18 p.m. - 11:39 p.m. During an interview and observation on 02/11/2026 at 12:00 p.m., Resident #1's family member said Resident #1 missed several showers over the last month. Resident #1's family member said the aide arrived so late in the evening that Resident #1 was ready to stay in bed at that time. Resident #1's family member said the aide gave Resident #1 a bed bath instead. Resident #1's family member said Resident #1's hair was not washed in over two weeks because she received the bed baths. Resident #1's family member said previously they requested a few times for Resident #1's scheduled shower time to be switched to days. Resident #1's family member said the ADON and DON said they would try to shower Resident #1 during the day shift if they had time. If not, she would have to get a shower in the evening. Attempted to interview Resident #1, and she was non-interviewable. Observation of resident #1 indicated her hair was greasy, limp and clumped together. During an interview on 02/11/2026 at 2:20 p.m., CNA A said Resident #1's family member wanted Resident #1 to be first when she comes on to shift at 6:00 p.m. CNA A said it was late by the time she made her rounds down to the end of the hall where Resident #1 was located at around 11 PM. CNA A said she would start with Resident #1's end of the hall first because, per the facility's schedule, that side of the hall showered at night. CNA A stated she was aware Resident #1's (continued on next page)

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
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family member requested a day shower for Resident #1. CNA A said if a resident requested a shower at a certain time, they should get it because it was their right but not everyone could have a shower on the day shift. CNA A said it was important to respect the residents' choices because the facility was their home and the residents had rights. During an interview on 02/11/2026 at 4:48 p.m., the DON said she was aware Resident #1's family requested for her to receive a shower on the day shift; however, they had a standard bathing schedule based on which side of the hall the resident resided on and based on where Resident #1's room, she was supposed to get a shower on the night shift. The DON said they agreed to give some of Resident #1's showers on the day shift, when the day shift was not busy, but because of the bath schedule they were not able to move Resident #1's showers to day shift. The DON said they did not offer Resident #1 to be moved to a different hall so she could get a shower when she wanted it. The DON said it was important to honor the residents' requests, but not everyone could receive a shower on the day shift.During an interview on 02/11/2026 at 5:05 p.m., the ADON said Resident #1's family member requested Resident #1 get a shower on the day shift. The ADON said she thought Resident #1's family member agreed to the staff accommodating that request by some of Resident #1's showers would be given during the day when the day shift was able to do so. The ADON stated sometimes Resident #1's family member would forget their agreed upon circumstances. The ADON said the facility has a standardized bathing scheduling based upon room location. Due to Resident #1's room location, she was showered on the night shift. The ADON said all the staff were responsible for ensuring the residents' rights were being followed, and their choices were respected but not all the residents could be showered on the day shift. During an interview on 02/22/206 at 5:15 p.m., the Administrator said if Resident #1's family member requested a shower during the day shift then the shower should be person centered and scheduled to be given during the day shift. The Administrator said it was important for the staff to respect the residents' choices because it was important for the staff to respect the residents' rights. The Administrator stated she was not aware of Resident #1's family member request because it would have been honored. Record review of the facility's policy titled, Resident Rights, last reviewed 02/21/2021, indicated, .The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promptly resolve grievances for 1 of 6 residents (Resident #1) reviewed for grievances.The facility failed to ensure a grievance was filed when Resident #1's family member reported to the ADON a request for Resident #1's showers be given on the day shift to accommodate Resident #1's sleep schedule was not honored. This failure could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Record review of a face sheet, dated 02/11/2026, indicated Resident #1 was a [AGE] year-old female, admitted [DATE], and re-admitted [DATE], with diagnoses including Alzheimer's early onset (a brain disease that slowly damages your memory, thinking, learning and organized skills), muscle weakness, abnormalities of gait and mobility, other lack of coordination, hypertension (high blood pressure). Record review of the Comprehensive MDS assessment, dated 01/29/2026, indicated Resident #1 was able to make herself understood and was understood by others. The MDS assessment indicated Resident #1 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #1 was dependent on staff for showering/bathing self. Record review of Resident #1's care plan reviewed 01/16/2026 indicated she had a self-care deficit and required assistance by staff for showering. Resident #1's care plan did not indicate her shower preferences. Record review of grievance logs, dated 11/01/2026 - 02/11/2026, did not indicate any grievances filed by the family member of Resident #1. During an interview and observation on 02/11/2026 at 12:00 p.m., Resident #1's family member said Resident #1 missed several showers over the last month. Resident #1's family member said the aide arrived so late in the evening that Resident #1 was ready to stay in bed at that time. Resident #1's family member said the aide gave Resident #1 a bed bath instead. Resident #1's family member said Resident #1's hair was not washed in over two weeks because she received the bed baths. Resident #1's family member said previously they requested a few times for Resident #1's scheduled shower time to be switched to days. Resident #1's family member said the ADON and DON said they would try to shower Resident #1 during the day shift if they had time. If not, she would have to get a shower in the evening. Resident #1's family member said they discussed and requested the shower be changed to days until blue in the face and blood pressure was high. Resident #1's family member said they had specifically requested with the ADON. Attempted to interview Resident #1, and she was non-interviewable. Observation of resident #1 indicated her hair was greasy, limp and clumped together. During an interview on 02/11/2026 at 4:48 p.m., the DON said she was aware Resident #1's family member requested for her to receive a shower on the day shift. The DON said the ADON had brought the matter to her attention along with other staff on different occasions. The DON said she did not know this was considered a grievance because the facility had a standard bathing schedule based on which side of the hall the resident resided on and based on Resident #1's room, she was supposed to get a shower on the night shift. The DON said they did not offer Resident #1 to be moved to a different hall so she could get a shower when she wanted it. The DON said it was important to honor the residents' requests, but not everyone could receive a shower on the day shift.During an interview on 02/11/2026 at 5:05 p.m., the ADON said Resident #1's family member requested Resident #1 get a shower on the day shift. The ADON said she could not recall the dates but Resident #1's family member made the request more than once. The ADON said she was unsure of the facility's grievance process and did not write down Resident #1's family member's requests to be followed up on. The ADON said she discussed the request during morning meeting with other staff and felt the facility was trying to accommodate Resident #1's family member's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	request to the best of their ability as not everyone was able to have a shower on day shift. During an interview on 02/22/2026 at 5:15 p.m., the Administrator said she was primarily responsible for keeping up with the grievance log, following up and resolving grievances. The Administrator said when a resident filed a grievance a resolution was developed and completed within 2-3 days at the very longest. She said if a resolution could not be completed in that time frame, a written update was provided to the Administrator The Administrator said if Resident #1's family member's requests were documented as a grievance she would have known about the incidents and educate the staff on the proper and appropriate resolutions for grievances and person-centered care, alleviating the issue promptly. The Administrator said grievances should be addressed in a timely manner, so the residents felt like they were heard. She said grievances not addressed timely could cause residents to have unresolved complaints.Record review of a facility Grievance Policy, dated 11/02/16, indicated, .The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Procedure . 4. As needed, the facility will take immediate action to prevent further potential violations of any resident rights while the alleged violation is being investigated 5. All grievances involving alleged violations of neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the abuse preventionist. 6. All written grievances decisions will include: The date the grievance was received A summary statement of .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 3 medication carts (Treatment Cart) reviewed for pharmacy services. 1. The facility failed to ensure the Treatment Cart was properly secured when it was left unattended on 01/29/26. 2. The facility failed to ensure the wound cleanser left on top of the Treatment Cart was properly secured on 01/29/26. These failures could place residents at risk for not receiving drugs and biologicals as needed and a drug diversion.Findings included: During an observation on 01/29/26 at 10:46 a.m., the Treatment Cart was observed on Hall A unlocked with a wound cleanser bottle sitting on top. The Treatment Cart was able to be opened by the surveyor and triamcinolone cream tubes (prescription cream applied to the skin to help redness and itchiness) were noted in the top drawer. Observation indicated no staff noticed or attempted to stop the surveyor from opening the cart. Residents and staff were observed by the unlocked treatment cart. During an interview on 01/29/2026 at 11:00 a.m., the Treatment Nurse said she usually locked the treatment cart because it contained items and some medications such as wound cleanser and creams that could be potentially dangerous if ingested by a resident. The Treatment Nurse stated she stepped into the shower room because an aide requested help with a resident and did not take the time to put the wound cleanser away and lock the treatment cart. During an interview on 01/29/2026 at 10:55 a.m., the Administrator stated she expected the Treatment Nurse to keep the treatment cart locked at all times to prevent any accidents from occurring such as a resident drinking or spraying a harmful substance into their eyes resulting in a potential injury. During an interview on 01/29/2026 at 3:35 p.m., the DON said she expected the treatment cart to be under the supervision of the Treatment Nurse directly or locked at all times to prevent accidental ingestion of any items that the cart held such as creams, ointments, and skin cleanser which could result in harm. The DON said she checked medication and treatment carts to ensure they stayed locked by conducting daily walks through the facility. Record review of the undated facility's policy titled, Medication Storage in Facility, dated 03/2025, indicated, . Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 8. Potentially harmful substances (e.g. urine test reagent tablets, household poisons, cleaning supplies, and disinfectants) are clearly identified and stored in a locked area separate from medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify and follow-up with the ordering physician regarding laboratory results outside of clinical reference range for 1of 6 residents (Resident #3) reviewed for laboratory services.The facility failed to notify the physician promptly on 12/29/2025 at 01:32 p.m. of Resident #3's Urine Culture and Sensitivity laboratories results. This failure could place residents at risk of not receiving and managing medications at a therapeutic level. Findings included:Record review of Resident #3's face sheet, dated 01/06/2026, indicated an [AGE] year-old female, admitted to the facility on [DATE] and readmitted [DATE], with diagnoses including cerebrovascular disease (stroke), candidiasis (fungal infection), muscle weakness, abnormalities of gait and mobility, and dementia (memory loss).Record review of Resident #3's quarterly MDS assessment, dated 11/20/2025, indicated Resident #3 understood others and was understood by others. Resident #3 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #3 required maximum assistance with bathing and dependent on toileting. Record review of Resident #3's comprehensive care plan, with a revision date of 12/2/2024, indicated she had a self-care deficit, and she required assistance by staff for toileting. Record review of Resident #3's comprehensive care plan, with a revision date of 05/29/2025, indicated she was on prophylactic antibiotic therapy (prophylactic antibiotic therapy involves administering antibiotics before potential exposure to bacteria to prevent infection, particularly in high-risk medical situations) related to recurrent urinary tract infections with no interventions. Record review of Resident #3's progress note, dated 12/24/2025, indicated Resident #3 had increased agitation and exit seeking behaviors. The progress note indicated the physician was notified with new order received to collect Urine Analysis with Culture and Sensitivity. Record review of Resident #3's progress note, dated 12/25/2025, indicated the Urine Analysis with Culture and Sensitivity was collected using sterile technique. Record review of Resident #3's progress note, dated 12/26/2025, indicated Resident #3 with increased exit seeking behaviors. Record review of Resident #3's progress note, dated 12/27/2025, indicated Urine Analysis results were received and sent to physician. The Culture and Sensitivity were pending results from the lab.Record review of Resident #3's progress note, dated 12/27/2025, indicated Resident #3 set off the alarms when she attempted to exit the facility. Resident #3 was admitted to the secured unit with the ADON in receipt of Resident #3's medications (the ADON took Resident #3's medications to the secured unit) and Urine Analysis lab results. Record review of Resident #3's progress note, dated 12/28/2025, indicated Resident #3 with more confusion and attempts to elope and had feces on both hands and smeared on bedding. Record review of Resident #3's laboratory result report, dated 12/29/2025, indicated Resident #3's Urine Culture and Sensitivity results were abnormal and positive for Escherichia coli (bacteria found in the intestines of humans that can result in urinary tract infection). Record review of the facility's 24-hour report, dated 12/29/2025, did not indicate Resident #3's laboratory results were faxed to the doctor and required a follow up.Record review of Resident #3's progress notes, dated 12/29/2025, did not indicate Resident #3's Urine Analysis Culture and Sensitivity results.Record review of Resident #3's progress note, dated 12/30/2025, indicated the physician was notified of Urine Culture and Sensitivity results received on 12/29/2025 with no new orders and instructions to follow up with Resident #3's Urologist. The progress note indicated the facility left several messages with the office on call agent and faxed the lab results to Resident #3's urologist.Record review of Resident #3's progress note, dated 12/30/2025, indicated Resident #3 continued Keflex 250 milligrams (antibiotic) daily as urinary tract infection preventative.Record (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #3's progress note, dated 12/30/2025, indicated Resident #3's family member requested Resident #3 be sent out to the hospital for further evaluation.Record review of Resident #3's progress note, dated 12/30/2025, indicated Resident #3 was transferred to the hospital due to Escherichia coli (bacteria) in urine. Record review of Resident #3's progress note, dated 12/31/2025, indicated Resident #3 was returned to the facility from the hospital with a diagnosis of Urinary Tract Infection. Resident #3 was treated with Rocephin 1000mg in sterile water intravenous and Omnicef 300 milligrams, 1 tablet, by mouth for 7 days. Record review of Resident #3's order summary report, dated 01/06/2026, indicated the following order: Admit to secure unit due to history of elopement with active exit seeking behavior with a start date of 12/27/2025. During an attempted interview on 01/29/2026 at 2:00 p.m., Resident #3 was non-interviewable. During an interview on 01/30/2026 at 10:30 a.m., Resident #3's family member said when Resident #3 had increased behaviors it usually meant she had a UTI and they reported this concern to the ADON and Administrator on 12/25/25. Resident #3's family member said they waited multiple days for her UTI to be addressed. Resident #3's family member said since it was close to the holidays and no one was doing anything to treat Resident #3's UTI, they requested Resident #3 to be sent out to the hospital in order to prevent Resident #3 from becoming septic (infection in the blood).During an interview on 01/30/2026 at 11:40 a.m., the ADON said all nurses were responsible for following up on the lab results. She said nurse management discussed labs in the morning clinical meeting. The ADON said she worked on the secured unit on 12/29/2026. The ADON said she did not know why the lab for Resident #3 was not documented on the 24-hour report to ensure follow up was completed. The ADON said she could not recall anything regarding why Resident #3's labs were not sent to the physician on 12/29/2025 when the facility received them. The ADON said it was important for labs to be followed up on, so they did not miss anything.During an interview on 01/30/2026 at 12:00 p.m., the Regional Corporate Compliance said if there was a lab that needed to be followed up on, it would have been written on the 24-hour report. She said if it was not written on the 24 hours report it could get missed. She said if it was discussed in the clinical meeting, then it would have been addressed and charted. She said the nurses checked every shift for lab results and faxes. The ADON and DON should be checking every shift to ensure nothing was missed. She said by not following up with lab results any delays in sending to the physician could cause adverse effects to the residents. During an interview on 02/11/2026 at 05:10 PM, the Administrator said she expected the nurse to follow up with labs immediately once they were received. She said she expected, through the 24-hour report and clinical meetings, coordination of care would occur and prevent any delays in getting results from the labs or sending to physicians for new orders. The Administrator said the charge nurses were responsible to check during their shifts and the DON and ADON would oversee the processes. Record review of the facility's policy Lab and Diagnostic Test Results- Clinical Protocol revised November 2018, indicated . 1. When test results are reported to the facility, a nurse will first review the results. A. if a team member who first received or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow coordinate the procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 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 1 of 6 residents (Resident #2).The facility failed to ensure CNA B and CNA C changed their gloves and performed hand hygiene after removing Resident #2's soiled brief and before applying barrier cream when they provided incontinent care on 01/29/26.This failure could place residents at risk of exposure to communicable diseases, cross-contamination, and infections.Findings Included:Record review of a face sheet, dated 02/11/2026, indicated Resident #2 was a [AGE] year-old female, admitted [DATE], with diagnoses including congestive heart failure (heart does not pump effectively), abnormalities of gait and mobility, chronic pulmonary edema (a buildup of fluid in the lungs resulting in breathing difficulty), Type 2 diabetes mellitus (too much sugar in the blood, muscle weakness, other lack of coordination. Record review of the Comprehensive MDS assessment, dated 12/02/2025, indicated Resident #2 was able to make herself understood and was understood by others. The MDS assessment indicated Resident #1 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #2 was dependent on staff for toileting and required maximum assistance for showering/bathing self. Record review of Resident #2's care plan reviewed 12/21/2025 indicated she had a self-care deficit, and she required assistance by staff for toileting. During an observation on 01/29/2026 at 02:39 p.m., CNA B and CNA C entered Resident #2's room to provide incontinent care. CNA B and CNA C washed their hands and applied gloves. During the incontinent care process, CNA B and CNA C failed to change their gloves and perform hand hygiene after removing Resident #2's soiled brief before applying barrier cream.During an interview on 01/29/2026 at 2:55 p.m., CNA C said when providing incontinent/perineal care, she was supposed to remove the soiled gloves and perform hand hygiene. CNA C said she did not change the soiled gloves and perform hand hygiene because she forgot. CNA C said she should have used hand sanitizer and changed the soiled gloves. CNA C said it was important to change gloves and perform hand hygiene while providing peri care, so she did not cross contaminate and increase the possibilities of urinary tract infections.During an interview on 01/29/2026 at 2:59 p.m., CNA B said when providing incontinent /perineal care, she was supposed to remove the soiled gloves and perform hand hygiene before applying the barrier cream. CNA B said she did not change the soiled gloves and perform hand hygiene because she forgot and was nervous with the surveyor present. CNA B said she should have used hand sanitizer or washed her hands in the bathroom between glove changes. CNA B said it was important to change gloves and perform hand hygiene while providing peri care, so she did not cross contaminate and increase the possibilities of urinary tract infections.During an interview on 02/11/2026 at 4:48 p.m., the DON said hand hygiene should be performed in between glove changes. The DON said soiled gloves should be changed prior to applying barrier cream. The DON said she, the charge nurses, and the ADON, were responsible for ensuring the CNAs performed adequate hand hygiene and proper procedures during incontinent and peri care. The DON said random checks were done with the CNAs to ensure they were performing proper hand hygiene and incontinent care. The DON said it was important to perform hand hygiene properly during incontinent care because the residents could get a urinary tract infection and sepsis (infection in the bloodstream). During an interview on 02/11/2026 at 5:05 p.m., the Administrator said she expected all the staff to do proper hand washing and glove changes appropriately per the facility's policy. The Administrator said the charge nurses and nurse management were responsible for ensuring the CNAs performed proper incontinent care. The Administrator said not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing hand hygiene adequately during incontinent care and peri care could lead to the spread of disease, bacteria and infections. Record review of a skills check off entitled CNA Proficiency Audit, dated 01/14/2026, indicated CNA C was competent in perineal care/incontinent care.Record review of a skills check off entitled CNA Proficiency Audit, dated 12/08/2025, indicated CNA B was competent in perineal care/incontinent care. Record review of the facility's policy titled, Perineal Care, dated 05/11/2022, An incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services. This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition. If heavily soiled, use an incontinence pad, brief, towel, or wipes to remove soiling, from front to back, prior to performing perineal care Do not wipe more than once with the same surface Doffing and discarding of gloves are required if visibly soiled Always perform hand hygiene before and after glove use.