

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Gilmer Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460</p> <p>Based on interviews, observations, and record review, the facility failed to ensure each resident was informed before or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 1 of 3 residents (Resident #54) reviewed for Medicare/Medicaid coverage.</p> <p>The facility failed to ensure Resident #54, was given a SNF ABN (a document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility.</p> <p>This failure could place residents at risk for not being aware of changes to the services provided.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 12/11/24 indicated Resident #54 was admitted on [DATE] and was an [AGE] year-old male with diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), high blood pressure, and shock (occurs when organs do not get enough blood).</p> <p>Record review of an undated billing statement indicated Resident #54 was admitted on [DATE] with Medicare part A for skilled nursing care and the last day of coverage was 08/31/24. On 09/01/24, Resident #54 remained in the facility on Medicaid services.</p> <p>Record review of the electronic record dated from 06/19/24 to 12/11/24 indicated Resident #54's family or responsible party had not been given a SNF ABN (a document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility.</p> <p>During an observation on 12/11/24 at 10:50 a.m., Resident #54 resided on the secure unit and was unable to answer questions about billing matters.</p> <p>During an interview on 12/11/24 12:33 p.m., the MDS nurse said she just learned she was responsible for the ABN letters and would receive training today.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/11/24 12:38 p.m., the Administrator said she was unable to voice negative outcomes because she was not sure if they had to complete the SNF ABN form and she said she would reach out to her corporate for training.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664</p> <p>Based on interview and record review the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for 1 of 6 residents reviewed for PASRR services. (Resident #1)</p> <p>* The facility did not have Resident #1's hospice representative present for the PASRR IDT meeting dated 04/09/24 requesting specialized PT services.</p> <p>* The facility did not have Resident #1's hospice representative present for the PASRR IDT meeting dated 10/25/24 requesting specialized OT services.</p> <p>These failures could affect the residents with intellectual and developmental disabilities by placing them at risk of a delay in or not receiving specialized services that would enhance their highest level of functioning.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 12/11/24 indicated Resident #1 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included seizures and intellectual disabilities.</p> <p>Record review of a PASRR Level 1 dated 06/10/21 indicated Resident #1 was marked yes for ID and DD.</p> <p>Record review of a PASRR Evaluation dated 06/23/21 indicated Resident #1 met criteria for ID and DD.</p> <p>1. Record review of a letter from the PASRR Unit dated 05/01/24 indicated they were requesting more information for Resident #1 to have Nursing Facility Specialized Services of PT.</p> <p>Record review of a letter from the PASRR Unit dated 05/08/24 indicated they denied PT because they did not receive the information by the deadline.</p> <p>Record review on 12/11/24 at 11:00 a.m. with the DOR of the LTC Online Portal indicated the following entries:</p> <p>* on 04/30/24 at 03:44 p.m. -HHSC records indicate that the most recent IDT meeting did not include the hospice provider as a participant per IL 19-03</p> <p>* on 05/01/24 at 11:39 a.m. -HHSC records indicate that the most recent IDT meeting did not include the hospice provider as a participant per IL 19-03</p> <p>During an interview on 12/11/24 at 11:10 a.m. the MDS Nurse said she was not involved with the PASRR information in May 2024, but it looked like the hospice representative was not in the meeting.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #1's PCSP dated 09/17/24 indicated Resident #1, the LIDDA, the DON, and the DOR attended the meeting. The hospice representative was not present for the meeting.</p> <p>Record review of a letter from the PASRR Unit dated 11/27/24 indicated they were requesting more information for Resident #1 to have Nursing Facility Specialized Services of OT.</p> <p>Record review on 12/11/24 at 11:00 a.m. with the DOR of the LTC Online Portal indicated on 11/20/2024 at 02:17 p.m. -HHSC records indicate that the most recent IDT meeting did not include the hospice provider as a participant per IL 19-03</p> <p>During an interview on 12/11/24 at 11:00 a.m. the DOR said the MDS Nurse told him the hospice representative had not attended the meeting in October 2024, so she was having to reconduct the meeting with the hospice representative. He said who scheduled the meeting should include all persons involved in the resident's care or it could delay services.</p> <p>During an interview on 12/11/24 at 11:10 a.m. the MDS Nurse said she was aware of the hospice representative issue, but they could not attend a meeting until 12/15/24, after the due date of information needed to the PASRR Unit. She said it could cause a delay in or non-payment for services.</p> <p>During an interview on 12/11/24 at 10:28 a.m. the Administrator said she was not aware of the denial letter for Resident #1. She said she expected everything to be done for the PASRR residents so services are not delayed or denied.</p> <p>PASRR and Hospice Criteria:</p> <p>When the IDT agrees that a hospice recipient needs NF specialized services, the NF must submit prior authorization requests for all required assessments and NF specialized services via the Authorization Request for PASRR Nursing Facility Specialized Services (NFSS) form on the LTC Online Portal.</p> <p>SS will be discussed and can be recommended based on the individuals needs and medical condition. Specialized services for now include NF and LIDDA SS. If final approval is given, it may also include LMHA/LBHA services. Notification will be provided of any further changes. NFs will still submit requests for NF SS the same way they do now. No changes. There will be a delay in the process of holding the L TCMI for lack of IDT meetings for hospice cases. This will give providers time to schedule meetings and enter data into the portal. We expect it to take several months before any L TCMI holds for hospice-missing IDTs will be implemented</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664</p> <p>Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed for 1 of 2 residents reviewed for new admissions (Resident #108).</p> <p>The facility failed to include Resident #108's diagnosis of depression and antidepressant medication the baseline care plan.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 12/10/24 indicated Resident#108 was an [AGE] year-old male admitted on [DATE].</p> <p>Record review of the physician orders dated December 2024 indicated Resident #108 had a diagnosis of depression and an order dated 12/05/24 for Amitriptyline 25mg one time daily for depression.</p> <p>Record review of the baseline care plan dated 12/04/24 for Resident#108. There was no care plan to address his diagnosis of depression or his antidepressant medication Amitriptyline.</p> <p>During an interview on 12/10/24 at 02:42 the DON said she and the ADON were responsible for the care plans. She said the baseline care plan information should pull from the resident's transfer papers. The DON said Resident #108 should have a care plan to address his diagnosis of depression and his antidepressant medication. She said this could cause his depression and medication not be monitored appropriately.</p> <p>During an interview on 12/11/24 at 10:28 a.m. the Administrator said care plans should be complete by the nursing staff assigned or their needs could be missed.</p> <p>Record review of an undated Base Line Care Plans policy Indicated .The baseline care plan will reflect the resident's stated goals and objectives, and include interventions that address his or her current needs. It will be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable. Because the baseline care plan documents, the interim approaches for meeting the resident's immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan. Facility staff will implement the interventions to assist the resident to achieve care plan goals and objectives</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664</p> <p>33460</p> <p>Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 15 residents. (Resident #11, #28, and #34)</p> <p>The facility failed to develop a care plan for Resident #11, #28, and #34's PASRR (Preadmission Screening and Resident Review) positive status.</p> <p>This failure could place the residents at risk of not receiving care and services to maintain their highest level of well-being.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of a face sheet dated 10/10/24 indicated Resident #11 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and bipolar type (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). <p>Record review of Resident #11's PASRR Level 1 screen dated 11/16/22 indicated she was PASRR positive status for mental illness and intellectual disability.</p> <p>Record review of the most recent annual MDS assessment dated [DATE] indicated Resident #11 had a BIMS score of 12 indicating moderately impaired cognition and was currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Level II Preadmission Screening and Resident Review (PASRR) Conditions indicated serious mental illness and intellectual disability. The assessment indicated Resident #11 with a diagnosis of schizoaffective disorder and was taking an antipsychotic medication during the last 7 days.</p> <p>Record review of Resident #11's care plans revised 11/04/24 did not indicate Resident #11 had a PASRR positive status.</p> <p>Record review of Resident #11's December 2024 MAR indicated she received Abilify 10 mg daily for schizoaffective disorder and Olanzapine 10 mg daily at bedtime for schizoaffective disorder.</p> <p>Record review of physician's orders dated 12/10/24 indicated Resident #11 was prescribed Abilify (treats severe mental health conditions) 10 mg one time a day for schizoaffective disorder with a start date of 07/04/24 and Olanzapine (treats mental health disorders) 10 mg daily at bedtime for schizoaffective disorder with a start date of 07/03/24.</p> <p>During an observation 12/09/24 at 11:00 a.m., Resident #11 was lying in bed and said she was treated well and received needed care.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of face sheet dated 12/10/24 indicated Resident #28 was admitted on [DATE] and was a [AGE] year-old female with diagnoses cerebral palsy and diabetes.</p> <p>Record review of the PASRR screen for Resident #28 dated 01/04/22 indicated she was PASRR positive status.</p> <p>Record review of the annual MDS assessment dated [DATE] indicated Resident #28 was currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Level II Preadmission Screening and Resident Review (PASRR) Conditions indicated intellectual disability. Diagnoses included cerebral palsy.</p> <p>Record review of the care plan dated 10/29/24 did not address Resident #28 PASRR positive status.</p> <p>3. Record review of physician orders for December 2024 indicated Resident #34 was a [AGE] year-old female admitted on [DATE]. She had a diagnosis of anxiety (persistent and excessive worry that interferes with daily activities) and an order dated 11/26/24 for Buspirone (antianxiety medication) 5 mg for anxiety.</p> <p>Record review of the care plan indicated Resident #34 had no care plan to address that she was PASRR positive.</p> <p>During an interview on 12/10/24 at 9:00 a.m., the RCN said the MDS nurse was responsible for care/planning.</p> <p>During an interview and record review on 12/10/24 at 09:10 a.m., the MDS nurse said Resident #11 was PASRR positive and should have been care planned as PASRR positive but was not. She said it was overlooked. She said the DON and the ADON were responsible for acute care plans, but she was responsible for PASRR care plans. The MDS nurse said she was educated on care planning and was aware PASRR positive status should be care planned. She said the resident risk of a PASRR positive status not care planned was possibly missed services.</p> <p>During an interview on 12/10/24 at 9:15 a.m., the MDS nurse said Resident #28 did not have a care plan that addressed PASRR status. She said if the PASRR was not addressed in the care plan, services could be missed.</p> <p>During an interview on 12/10/24 at 9:45 a.m., the DON said her expectation was for the PASRR positive residents to be addressed on the care plan or services could be missed.</p> <p>During an interview on 12/10/24 at 01:30 p.m., the ADON said herself and the DON were responsible for care planning any acute care plans including antibiotics and falls. She said the MDS nurse was responsible for care planning PASRR status. The ADON said Resident #11 was PASRR positive and needed positive PASRR status care planned. She said the MDS nurse was educated on care planning. The ADON said the risk to the resident of not having a positive PASRR status care planned was potentially missed extra needed services.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/24 at 01:37 p.m., the DON said Resident #11 was PASRR positive and needed a positive PASRR status care planned. She said the MDS nurse was responsible for care planning PASRR positive status. The DON said herself and the ADON were responsible for acute care plans including antibiotics and falls. She said the MDS nurse was educated on care planning PASRR positive status. She said the resident risk of not having positive PASRR status care planned was potential missed extra needed services. The DON said her expectation was for PASRR positive status to be care planned accurately and timely for all residents.</p> <p>During an interview on 12/10/24 at 02:20 p.m., the Administrator said Resident #11 was PASRR positive and should have been care planned as a positive PASRR status. She said the MDS nurse was responsible for PASRR care plans, and it was overlooked. The Administrator said the MDS nurse was educated on care plans. She said the resident risk of a resident with a positive PASRR status not care planned was potential missed service opportunities. The Administrator said her expectation was all PASRR positive residents have a PASRR care plan.</p> <p>During an interview on 12/10/24 at 02:48 p.m. the DON and RCN said care plans should be developed to address everything with a resident. The DON said Resident #34 did not have a care plan to address her PASRR positive status.</p> <p>Record review of the facility undated policy titled Comprehensive Care Planning indicated The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and the right to refuse treatment. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASAR and the resident's representative(s) .</p> <p>41057</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>30664</p> <p>Based on interview and record review the facility failed to ensure there was an RN for 8 consecutive hours 7 days a week for 1 of 1 facility reviewed for RN coverage.</p> <p>The facility did not have RN coverage for 8 consecutive hours on 11/28/24 (Thanksgiving Day).</p> <p>This failure could place residents at risk of lack of nursing oversight and a higher level of care.</p> <p>Findings included:</p> <p>Record review of the RN time sheets indicated there was no RN working on 11/28/24 (Thanksgiving Day).</p> <p>During an interview on 12/10/24 at 03:15 p.m. the DON said she did not work on Thanksgiving Day (11/28/24) and she was not sure if any other RN was assigned to work. She said there should be an RN 8 hours a day or any situation of a resident requiring an RN would not be done.</p> <p>During an interview on 12/11/24 at 10:15 a.m. the Administrator said the DON did not work on 11/28/24 and they did not get any RN to cover the day. She said ultimately it was her responsibility to ensure they had the RN coverage.</p> <p>During the exit on 12/11/24 at 02:55 p.m. the Administrator said they did not have a policy regarding RN coverage. She said they followed the regulations.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057</p> <p>Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) in 1 of 4 medication carts reviewed (Short Hall Nurse medication cart) (Resident #4's medication).</p> <p>A package of Resident #4's 14 one ml syringes filled with ABH gel (a combination medication of Ativan {antianxiety medication}, Benadryl, {medication that relieves symptoms of nausea, vomiting and dizziness, rash, and cough} and Haldol {an antipsychotic medication that calms you down}) for Resident #4 with an expiration date of 09/04/25 and a lot expiration date of 10/04/24, had been expired for 68 days and not removed from use.</p> <p>A package of Resident #4's 24 one ml syringes filled with ABH gel with an expiration date of 10/07/25 and a lot expiration date of 11/06/24 for Resident #4, had been expired for 35 days and not removed from use.</p> <p>This failure could place residents at risk for accidents, hazards, and not receiving therapeutic effects of medication.</p> <p>The findings included:</p> <p>Record review of Resident #4's face sheet dated 12/11/24 indicated a [AGE] year-old female admitted [DATE] with diagnoses included: dementia (a group of thinking and social symptoms that interfere with daily functioning) and anxiety (intense, excessive, and persistent worry and fear about everyday situations).</p> <p>Record review of Resident #4's quarterly MDS assessment with an ARD of 10/24/24 indicated the resident had a BIMS score of 8 indicating the resident had moderately impaired cognition. The assessment indicated she was diagnosed with dementia and anxiety.</p> <p>Record review of Resident #4's care plan with a revision date of 11/10/24 indicated she required antipsychotic medication and antianxiety medication with an intervention to give as prescribed by the physician and monitor for side effects and effectiveness.</p> <p>Record review of Resident #4's physician's order, dated 12/11/24, indicated she was prescribed ABH gel (Ativan 1mg/ Benadryl 25 mg/ Haldol 2 mg) topically to wrist every 4 hours as needed for anxiety/restlessness related to dementia with a start date of 09/04/24.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 12/11/24 at 09:45 a.m., during a review of Short Hall's Nurse's medication cart with LVN C, there was a package of 14, 1 ml syringes with a white medication label indicated for Resident #4 of ABH 1mg /25 mg /2 mg gel with a drug expiration date of 09/04/25 and a yellow label indicated compounded in our pharmacy by the direction of your doctor with second yellow label indicated lot expiration date of 10/04/24. Observed a package of 24, 1 ml syringes with a white label for Resident #4 with ABH 1mg /25mg /2mg gel with a drug expiration date of 10/07/25 and a yellow label indicated compounded in our pharmacy by the direction of your doctor with second yellow label indicated lot expiration date of 11/06/24. LVN C said the medications were not expired they checked it by the white sticker indicating 09/04/25 and 10/07/25. After surveyor intervention LVN C called the pharmacy and said the medications were expired on the yellow label date, 10/04/24 and 11/06/24. She said they should have been removed from the medication cart on expiration date. She said she had been checking the medications with the expiration date label not the yellow lot expiration date label. She misunderstood the dates, but she had not administered the medication. LVN C said the nurses administrating medication off the medication cart were responsible for removing expired medication. She said she was educated in removal of expired medication from the nurse's medication cart on the expiration date. LVN C said the resident risk of expired medication not removed from the nurse's medication cart was the medication could be administered to a resident and not be as effective as prescribed. She said the Pharmacy Consultant checked monthly for expired medication.</p> <p>During an observation and interview on 12/11/24 at 12:19 p.m., Resident #4 was lying in bed, she said she received her medication as needed and her medication that was put on her skin helped her relax.</p> <p>During an interview phone on 12/11/24 at 10:37 a.m., Pharmacist B said Resident #4 had a batch of ABH gel syringes compounded on 09/04/24 that expired on 10/04/24, and a batch of ABH gel syringes compounded on 10/07/24 that expired 11/06/24. She said the compounded ABH gel expired 30 days after compounded as listed on the yellow label indicating lot expired date. Pharmacist B said the medication would decrease in effectiveness each day after the expiration date but would not hurt the resident. She said there were no studies of how much of a decrease in effectiveness.</p> <p>During an interview on 12/11/24 at 11:11 am the DON said the nurses were responsible for ensuring expired medication was removed from the nurse's medication carts and the Pharmacy consultant was the double check to remove expired medication. She said the Pharmacy consultant's last onsite visit was on 10/02/24, the unit nurse's medication cart was checked, and she did a computer check of medication on 12/10/24. She said the Pharmacy consultant did not check the short hall medication cart for expired medication at that time. The DON said she checked the nurse's medication carts on 12/09/24 but checked the wrong expiration date. She said the facilities' pharmacy marks out the expiration date if a medication was compound or changed to ensure staff do not check the wrong date. The DON said the expired medications were from a hospice pharmacy that did not mark out the incorrect expiration date when the medication was compounded. The DON said the nurses were educated on removal of expired medication off nurse's medication carts. She said the discrepancy of the white medication label indicated medication expired on a certain date and the yellow label indicated the lot expiration date was the reason it was overlooked. She said the resident risk was a medication administered after the expiration date may not have the proper effect of the medication on the resident. The DON said her expectation was all expired medication removed on the expiration date and when a resident expired or discharged all their medication removed immediately and properly discarded.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Gilmer Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 12/11/24 at 11:24 a.m., the Pharmacy consultant said the nurses or anyone giving medication were responsible for ensuring expired medication was removed from the nurse's medication carts. She said she was a double check to remove expired medication and did periodic medication cart audits during onsite visits but did not review every cart on every visit. She said her last visit was on 10/02/24 and she only reviewed the unit nurse medication cart. The Pharmacy consultant said the resident risk of ABH gel on the nurse's medication cart after the expiration date was it could be less effective for the resident but not harmful.</p> <p>During an interview on 12/11/24 at 11:35 a.m., the ADON said the nurses were responsible for ensuring expired medication was removed from the nurse's medication carts. She said herself and the DON checked the medication carts weekly for expired medication. She said the discrepancy of the white medication label indicated medication expired on a certain date and the yellow label indicated the lot expiration date was the reason the expired medications were overlooked. The ADON said the nurses should have called the pharmacy and clarified the expiration date. She said the staff were educated on removal of expired medication off medication carts. The ADON said the resident risk was a medication administered after the expiration date was medication could be less effective.</p> <p>During an interview on 12/11/24 at 12:00 p.m., the Administrator said the nurses were responsible for ensuring expired medications were removed from their medication carts. She said the nurses were educated on removal of expired medication from the medication carts. She said the nurse managers, ADON and DON double checked to ensure expired medication was removed from the nurse medication carts. She said the treatment nurse checked the treatment cart for expired medication. The Administrator said the nurses possibly were checking the typed drug expiration date on the label like on a prescription bottle like they were used to checking. She said the nurses did not take into account the added label of the compounded date. The Administrator said the resident risk of a medication administered after the expiration date was potential lower potency of the received medication. She said her expectation was if a medication was expired to be removed from the medication cart and properly discarded.</p> <p>During an interview on 12/11/24 at 12:31 p.m., the Regional Compliance Nurse said the nurses giving medication were responsible for removal of expired medication off the nurse's medication carts. She said the ADON and DON were the back up to double check and ensure expired medications were removed from the nurse's medication carts. She said the nurses were educated on removal of expired medication from the medication carts. The Regional Compliance Nurse said the nurse's looked at the wrong date was the reason the expired medication was still on the medication carts. She said the facilities pharmacy marked out the expiration date if the expiration date changes so there is no misunderstanding, and the hospice pharmacy did not do that. She said she checked the medication carts on 12/09/24 for expired medication and looked at the wrong expiration date. The Regional Compliance Nurse said the resident risk was the resident may receive medication that may not be as effective as prescribed.</p> <p>During a phone interview on 12/11/24 at 3:20 p.m., LVN D said the nurses providing medication were responsible for ensuring expired medication was removed from their medication carts. She said the ADON and Pharmacy Consultant double checked the medication carts for expired medication monthly. LVN D said she knew to remove expired medication off her medication cart but could not remember if she had officially received an in-service over removal of expired medication off her cart. She said she usually checks every medication for the expiration date before giving it, but she did not check Resident #4's ABH gel on 12/10/24 before she gave it. LVN D said the resident risk of a medication given after the expiration date was the medication may not be as effective.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gilmer Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 703 Titus Street Gilmer, TX 75644	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a facility policy dated 2003, titled, Drug Destruction Policy, indicated, . Nursing staff will submit to Director of Nursing any controlled medication and any applicable log that has expired, been discontinued by physician or that had been prescribed to a resident who no longer resides at the facility</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>33460</p> <p>Based on observations, interviews, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for essential equipment.</p> <p>The facility did not ensure the gas stove was in safe operating condition with the pilot light staying lit and allowing gas to leak.</p> <p>This failure could place the residents at risk of a fire and not receiving their meals in a timely manner.</p> <p>Findings included:</p> <p>During an observation and interview on 12/9/24 at 8:00 a.m., [NAME] A lit the burners on the stove. 1 of the 6 burners (back left burner) did not light using the pilot light and then would not light with a long lighter. She said she would report this to the maintenance supervisor.</p> <p>During an interview on 12/9/24 at 10:30 a.m., the maintenance supervisor said the pilot light on the stove required to be cleaned at times and said he would check the stove today. He said if the pilot light did not light the burner the stove would not work right.</p> <p>During an interview on 12/10/24 at 11:00 a.m., the Administrator said her expectation was for the stove to light with the pilot light. She said the facility did not have a policy about equipment, however the stove should work properly.</p> <p>During an interview on 12/10/24 at 11:15 a.m., the maintenance supervisor said he had cleaned the pilot light and removed a fan in the kitchen. He said he reminded the dietary staff if any problems with the pilot lights to report it to him.</p>