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	04/06/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure that residents were free from neglect 1 of 3 (Resident #1) residents reviewed for neglect. The facility failed to have an effective system in place for referrals resulting in Resident #1 not receiving a referral to the vascular specialist as ordered by his primary care physician and having an above the knee amputation to his right leg. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 4/04/23 at 3:00 p.m. While the IJ was removed on 4/06/23, the facility remained out of compliance at actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could result in residents not being seen by physicians when needed and lead to further decline in health status, harm, or death. Findings Include: 1. Record review of the face sheet dated 4/05/2023 indicated Resident #1 was admitted to the facility on [DATE] with diagnoses including COPD (a group of lungs diseases that block airflow and make it difficult to breathe), atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and difficulty walking. Record review of the physician orders dated 4/05/2023 indicated Resident #1 had an order for wound care to the right toes to cleanse with normal saline, pat dry, apply betadine moistened gauze, apply calcium alginate (a dressing used on moderate to heavy draining wounds during the transition from debridement to repair phase of wound healing) daily and as needed for wound care and infection prevention starting on 3/22/2023. Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 11 and was moderately cognitively impaired. The MDS indicated Resident #1 did not reject evaluation or care. The MDS indicated Resident #1 required extensive assistance with bed mobility, transferring, toileting, personal hygiene, and dressing. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an undated care plan indicated Resident #1 had impaired cognitive function or impaired thought process related to impaired decision-making abilities. Record review of the nursing progress note dated 2/28/2023 written by LVN F indicated nursing staff was having difficulty locating Resident #1's pedal pulse (foot pulse) to the right lower extremity. The nursing progress note indicated Resident #1's capillary refill was less than 3 seconds to right foot, excluding the second toe. The nursing progress note indicated a new order was received for Resident #1 to have a venous and arterial doppler to the right lower extremity. Record review of the right lower extremity arterial doppler (an ultrasound exam of the arteries on the legs that can help evaluate whether there are blockages caused by plaque in the arteries) report dated 3/01/2023 indicated Resident #1 had moderated atherosclerotic cardiovascular disease. Record review of the right lower extremity venous doppler (an ultrasound exam that evaluates blood as it flows through a blood vessel including the body's major arteries and veins) report dated 3/01/2023 indicated Resident #1 had superficial thrombophlebitis (an inflammatory disorder of superficial veins with coexistent venous thrombosis (blood clot)) of the greater saphenous vein and no deep vein thrombosis. Record review of the nursing progress note dated 3/02/2023 written by the Wound Care Nurse indicated Resident #1's doppler results were sent to the primary care physician. The nursing progress note indicated the primary care physician said Resident #1 needed a referral to a vascular specialist. The nursing progress note indicated the nurse on the floor was aware of the referral and would complete the task. Record review of the nursing progress note dated 3/03/2023 written by the Wound Care Nurse indicated the vascular specialist office was called to make an appointment for Resident #1. The nursing progress note indicated a voicemail was left at the vascular specialist's office and the facility was awaiting a phone call back. Record review of the nursing progress note dated 3/13/2023 written by the Wound Care Nurse indicated the facility had spoken with the vascular specialist's office on 3/09/23 regarding the previous voicemail left concerning Resident #1 getting an appointment. The nursing progress note indicated the vascular specialist's office would let the facility know by the end of the day or by the next day if a referral was received. The nursing progress note indicated the vascular specialist's office did not call back. The nursing progress note indicated the referral was discussed with the nurse practitioner on 3/10/2023. The nursing progress note indicated the nurse practitioner said the primary care physician's office did not do the referrals, but that it should be the facility's social worker who sends the referral. The nursing progress note indicated the social worker was not aware of what was needed for the referral. The nursing progress note indicated the nurse practitioner and the DCO were notified due to Resident #1's right lower extremity. The nursing progress note indicated the facility talked with the vascular specialist's office and the vascular specialist's office said they had not received a referral for Resident #1. The nursing progress note indicated the DCO was notified and will take care of it. Record review of the nursing progress note dated 3/28/2023 written by LVN F indicated Resident #1's right foot and toes were looking significantly worse. The nursing progress note indicated orders were received to transport Resident #1 to the emergency room for further evaluation and treatment. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the hospital records dated 3/28/23 indicated the chief complaint for Resident #1's emergency room visit was wound check. The hospital records indicated the toenail on the 4th right toe came off and the facility staff noted a hole in the toe. The hospital records indicated Resident #1 had dressed wounds to Lt foot. The hospital records indicated Resident #1 had erythema (reddening) and significant discoloration of all toes on right foot with foul smell. The hospital records indicated Resident #1 had ulcers on the 3rd and 4th toes on right foot. The hospital records indicated Resident #1 had decreased sensation to right foot. Record review of the hospital records dated 3/30/23 indicated Resident #1 was admitted from the facility with necrotic right foot and toes. The hospital records indicated Resident #1 was scheduled for an above the knee amputation on 3/31/2023. During an interview on 3/31/23 at 2:25 pm the receptionist at the venous specialist's office said they had never seen Resident #1. The receptionist at the vascular specialist's office said they did not have Resident #1 in their computer system and had no record of a referral. During an interview on 3/31/23 at 2:29 pm, the nurse practitioner said the referral for Resident #1 to see a vascular specialist was regarding vascular issues and arterial blockages. The nurse practitioner said she was unsure how advanced Resident #1's arterial/venous damage was at that time. The nurse practitioner said she would not be comfortable saying whether seeing the vascular specialist would have prevented Resident #1 from such an advanced amputation to right leg. During an interview on 3/31/2023 at 2:55 p.m. the SW said she had called the vascular specialist's office approximately 2 weeks ago. The SW said the vascular specialist's office said they were booked and short-handed. During an interview on 3/31/2023 at 2:56 p.m. the ADCO said the facility had asked the primary care physician's office to send a referral to the vascular specialist. The ADCO said the vascular specialist's office had said the referral had to come from the primary care physician's office. The ADCO said she had called the vascular specialist's office to find out what information they needed for a referral and had not received a call back. The ADCO said Resident #1's right lower extremity had worsened over the past 2 weeks. The ADCO said Resident #1 was sent to the emergency room so they would be taken seriously. During an interview on 3/31/23 at 3:32 pm, the Wound Care Nurse said she did not know if a referral was sent to the vascular specialist's office for Resident #1. The Wound Care Nurse said the DCO was supposed to talk to the SW regarding the referral for Resident #1 to the vascular specialist. The Wound care nurse said the nurse practitioner said the physician's office did not send referrals and that the facility's SW needed to send the referral to the vascular specialist for Resident #1. The Wound Care Nurse said Resident #1's right leg had significantly worsened over the past month. The Wound Care Nurse said Resident #1 was placed on antibiotics for the wounds to his right toes versus being sent out to the hospital. The Wound Care Nurse said Resident #1 was seen by the wound care nurse practitioner every Thursday at the facility. The Wound Care Nurse said Resident #1 did not have any discoloration to his legs but had pitting edema to both legs. The Wound Care Nurse said Resident #1's toes had worsened over the past month. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/03/2023 at 3:47 p.m. the primary care physician said he was informed of the referral for Resident #1 not being sent to the vascular specialist on 3/28/2023. The primary care physician said there was no way to know if Resident #1 had gotten into the vascular specialist if it would have prevented such an advanced right leg amputation. The primary care physician said he was aware of the wounds on Resident #1's toes. The primary care physician said he felt Resident #1 needed a referral to the vascular specialist due to the wounds on his right toes. During an interview on 4/04/2023 at 1:45 p.m. the SW said she handled referrals to mobile optometry, podiatry, hearing, and dental services. The SW said she had never done a referral to a physician or specialist. The SW said she was told by the nursing staff referrals to a physician or specialist was supposed to come from the primary care physician. The SW said she sometimes made appointments/referred residents for optometry, podiatry, hearing, and dental services in the community. The SW said she had never been trained on sending a referral to a physician or specialist. During an interview on 4/04/23 at 1:52 p.m. the ADCO said the facility did not have a process for sending referral to physicians or specialists. The ADCO said the DCO had told her it was the primary care physician's responsibility to send referrals. During an interview on 04/04/23 at 1:54 p.m. the DCO said the physician/Medical Director told the facility they did not send referrals. The DCO said the facility cannot make referrals. The DCO said there was not a process in place for making/sending referrals. During an interview on 04/04/23 at 2:00 p.m. the EDO said for referrals, the charge nurse or SW would make the appointments. The EDO said the facility did not have a policy regarding referrals to outside physicians or specialists. The EDO said if the physician/Medical Director wrote an order for a resident to see an outside physician/specialist, the facility would call to start the process of getting the appointment made. The EDO was notified on 4/04/2023 at 3:20 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The EDO was provided the Immediate Jeopardy template on 4/04/2023 at 3:22 p.m. The facility's Plan of Removal was accepted on 4/06/2023 at 8:28 a.m. and included: In Response to the facility failure to have a referral system or policy in place, the Administrator immediately created and implemented a referral policy on 4-4-23 to ensure that no additional residents are affected by poor quality of care. To ensure no other residents were affected by the facility failure of not having a referral system in place, the Director of Clinical Operations or Assistant Director of Clinical Operations has completed a review all orders on 4-4-23, for any orders requiring physician and or specialist referrals to ensure referrals are handled in a timely manner. No additional missed referrals were found. In Response to the facility failure to follow up with physician, the Medical Director, Licensed Nurses, Social Worker and wound care specialist will be provided in-service education related to the referral process policy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Inservice: Physician referral process for sending residents to a specialist or outside physician services by obtaining the Medical Director's referral order beginning on 4-4-23 to be completed by 04-4-23, by the Administrator or Assistant Director of Nurse's which includes: Referral Policy: 1. Upon receiving directions or recommendations from a provider or nurse practitioner, whether a physician or nurse practitioner, the charge nurse is to contact the Medical Director immediately and enter an order in PCC. 2. The charge Nurse to notify the Director of Nurses and/or the Assistant Director of Nurses and the Social Worker of the referral. 3. Social Worker to call in referral order, confirm insurance, obtain doctor signature on forms if needed and make appointment with Specialist and arrange for appropriate transportation. 4. Administrator to be notified if referrals are refused or denied by physician or Medical Director immediately with the reason for the denial to determine if the resident needs to be sent out to hospital for further evaluation. If it has been found the resident does not need immediate referral, the Director of Nurses will continue to monitor during daily clinical meetings with charge nurses and treatment nurses for change of condition. If a change of condition is found the physician is to be immediately notified. 5. Newly hired nurses will receive in-service from the Assist Director of Nurses regarding physician referral during orientation process, and to be included in the nurse's information book or Brain Book at nurse's station. In response to the facility failure to send a referral to the vascular specialist, the Director of Nurses, Assistant Director of Nurses and Social Worker will be provided in service to obtain the necessary information from the specialist's office, including vascular specialist, for the referral requirements needed from the physician and obtain the required signature's or orders to accommodate the requirements for the specialist to ensure there are no delays in resident's delay in care. In-service provided to Director of Nurses, Assistant Director of Nurses, and Social Worker 04/04/23 by Administrator to be completed by 04/04/23. Validation/Monitoring Tools Director of Clinical Operations or Designee will validate staff knowledge base through random questioning. Director of Clinical Operations or designee will review any referral orders documented by reviewing orders in daily stand up meeting and clinical meetings to ensure appointments are being made, beginning 4-4-21. Director of Clinical Operations or designee has called to follow up with Resident affected by the Failure of Quality of Care 4-4-23. Information obtained was that the resident received an above knee amputation and is being discharged to another skilled nursing facility for rehab. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/06/2023 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of the chart audits for residents who had been referred to outside providers in March 2023 was performed with no other issues noted. Record review of the facility's undated Referral Policy was performed. The Referral Policy indicated the facility's newly implemented steps in ensuring referrals were made to outside providers in a timely manner. Record review of the facility's Brain Book located at the nurse's station indicated the referral policy had been added into the book and was available to the nursing staff at all times for reference. Record review and signature verification was performed on in-services dated 3/30/23 through 4/13/23 regarding the facility's Referral Policy Interviews of staff on 4/04/2023 between 11:03 a.m. and 11:48 a.m. (LVN A, RN B, LV C, RN D, RN E, ADCO, LVN F, SW, MDS nurse, Wound Care Nurse, and DON) were performed. During the interviews staff were able to correctly identify the process for referrals per the facility's Referral Policy. Interview with the Medical Director and nurse practitioner on 4/04/23 between 11:38 a.m. and 11:41 a.m. regarding the facility's referral policy indicated they had received and agreed with facility's Referral Policy. Both the Medical Director and nurse practitioner said this policy would help ensure residents received appointments and were seen by outside providers and specialists. On 4/06/2023 at 11:51 a.m., the EDO was informed the IJ was removed; however, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 (Resident #1) residents reviewed for quality of care. 1. The Facility Failed to follow-up with the physician regarding referral ordered 3/02/23 to the vascular specialist in a timely manner resulting in Resident #1 not being seen by the vascular specialist and having an above the knee amputation of the right leg on 3/31/23. 2. The facility failed to send a referral to the vascular specialist resulting in Resident #1 not being seen by the vascular specialist and having an above the knee amputation of the right leg on 3/31/23. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 4/04/23 at 3:00 p.m. While the IJ was removed on 4/06/23, the facility remained out of compliance at actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of harm or death related to not receiving proper care or death by not being seen by a specialist or another physician as ordered by their primary physician. Findings Include: 1. Record review of the face sheet dated 4/05/2023 indicated Resident #1 was admitted to the facility on [DATE] with diagnoses including COPD (a group of lungs diseases that block airflow and make it difficult to breathe), atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and difficulty walking. Record review of the physician orders dated 4/05/2023 indicated Resident #1 had an order for wound care to the right toes to cleanse with normal saline, pat dry, apply betadine moistened gauze, apply calcium alginate (a dressing used on moderate to heavy draining wounds during the transition from debridement to repair phase of wound healing) daily and as needed for wound care and infection prevention starting on 3/22/2023. Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 11 and was moderately cognitively impaired. The MDS indicated Resident #1 did not reject evaluation or care. The MDS indicated Resident #1 required extensive assistance with bed mobility, transferring, toileting, personal hygiene, and dressing. Record review of an undated care plan indicated Resident #1 had impaired cognitive function or impaired thought process related to impaired decision-making abilities. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing progress note dated 2/28/2023 written by LVN F indicated nursing staff was having difficulty locating Resident #1's pedal pulse (foot pulse) to the right lower extremity. The nursing progress note indicated Resident #1's capillary refill was less than 3 seconds to right foot, excluding the second toe. The nursing progress note indicated a new order was received for Resident #1 to have a venous and arterial doppler to the right lower extremity. Record review of the right lower extremity arterial doppler (an ultrasound exam of the arteries on the legs that can help evaluate whether there are blockages caused by plaque in the arteries) report dated 3/01/2023 indicated Resident #1 had moderated atherosclerotic cardiovascular disease. Record review of the right lower extremity venous doppler (an ultrasound exam that evaluates blood as it flows through a blood vessel including the body's major arteries and veins) report dated 3/01/2023 indicated Resident #1 had superficial thrombophlebitis (an inflammatory disorder of superficial veins with coexistent venous thrombosis (blood clot)) of the greater saphenous vein and no deep vein thrombosis Record review of the nursing progress note dated 3/02/2023 written by the Wound Care Nurse indicated Resident #1's doppler results were sent to the primary care physician. The nursing progress note indicated the primary care physician said Resident #1 needed a referral to a vascular specialist. The nursing progress note indicated the nurse on the floor was aware of the referral and would complete the task. Record review of the nursing progress note dated 3/03/2023 written by the Wound Care Nurse indicated the vascular specialist office was called to make an appointment for Resident #1, The nursing progress note indicated a voicemail was left at the vascular specialist's office and the facility was awaiting a phone call back. Record review of the nursing progress note dated 3/07/2023 written by RN B indicated Resident #'1 family reported the dressing to Resident #1's right foot was dirty and leaking pus. The nursing progress note indicated upon inspection Resident #1's dressing to his right foot was clean, dry, and intact. The nursing progress note indicated Resident #1's dressing to his right foot was freshly changed by the treatment nurse. The nursing progress noted indicated Resident #1 did not have any pus noted. Record review of the nursing progress note dated 3/10/2023 written by LVN A indicated a new order was received for the nurse practitioner for Resident #1 to start antibiotic therapy related to Resident #1's right foot being red and warm to the touch. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing progress note dated 3/13/2023 written by the Wound Care Nurse indicated the facility had spoken with the vascular specialist's office on 3/09/23 regarding the previous voicemail left concerning Resident #1 getting an appointment. The nursing progress note indicated the vascular specialist's office would let the facility know by the end of the day or by the next day if a referral was received. The nursing progress noted indicated the vascular specialist's office did not call back. The nursing progress note indicated the referral was discussed with the nurse practitioner on 3/10/2023. The nursing progress note indicated the nurse practitioner said the primary care physician's office did not do the referrals, but that it should be the facility's social worker who sends the referral. The nursing progress note indicated the social worker was not aware of what was needed for the referral. The nursing progress note indicated the nurse practitioner and the DCO were notified due to Resident #1's right lower extremity. The nursing progress note indicated the facility talked with the vascular specialist's office and the vascular specialist's office said they had not received a referral for Resident #1. The nursing progress note indicated the DCO was notified and will take care of it. Record review of the nursing progress note dated 3/18/2023 written by LVN G indicated Resident #1 was lying in bed, hanging his right leg off the bed. The nursing progress note indicated Resident #1 said he did not want his leg up. The nursing progress note indicated Resident #1 said his leg felt better hanging off the bed. The nursing progress note indicated Resident #1 was encouraged to elevate his right leg due to edema. The nursing progress note indicated Resident #1 chose not to elevate his leg. Record review of the nursing progress note dated 3/28/2023 written by LVN F indicated Resident #1's right foot and toes were looking significantly worse. The nursing progress note indicated orders were received to transport Resident #1 to the emergency room for further evaluation and treatment. Record review of the hospital records dated 3/28/23 indicated the chief complaint for Resident #1's emergency room visit was wound check. The hospital records indicated the toenail on the 4th right toe came off and the facility staff noted a hole in the toe. The hospital records indicated Resident #1 had dressed wounds to Lt foot. The hospital records indicated Resident #1 had erythema (reddening) and significant discoloration of all toes on right foot with foul smell. The hospital records indicated Resident #1 had ulcers on the 3rd and 4th toes on right foot. The hospital records indicated Resident #1 had decreased sensation to right foot. Record review of the hospital records dated 3/30/23 indicated Resident #1 was admitted from the facility with necrotic right foot and toes. The hospital records indicated Resident #1 was scheduled for an above the knee amputation on 3/31/2023. Record review of the hospital records last reviewed on 3/31/2023 indicated Resident #1's problem list included cellulitis and abscess of the toe on the right foot noted on 3/282023, peripheral vascular disease noted on 3/28/2023, skin ulcer of the bilateral feet noted on 3/28/2023, venous stasis (a condition in which veins have problems moving blood back to the heart) noted on 3/28/2023, and peripheral arterial disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) noted on 3/30/2023. During an interview on 3/31/23 at 2:25 pm the receptionist at the venous specialist's office said they had never seen Resident #1. The receptionist at the vascular specialist's office said they did not have Resident #1 in their computer system and had no record of a referral. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/31/23 at 2:29 pm the nurse practitioner said the referral for Resident #1 to see a vascular specialist was regarding vascular issues and arterial blockages. The nurse practitioner said she was unsure how advanced Resident #1's arterial/venous damage was at that time. The nurse practitioner said she would not be comfortable saying whether seeing the vascular specialist would have prevented Resident #1 from such an advanced amputation to right leg. During an interview on 3/31/2023 at 2:50 p.m. LVN F said she did not see Resident #1's feet often due to them being wrapped in wound dressing. LVN F said Resident #1 had edema to his bilateral feet. LVN F said the right foot was bluish in color at the beginning of March 2023. LVN F said Resident #1's family had asked his feet approximately 2 weeks prior. LVN F said she performed a dressing change on Resident #1's feet when the family had asked about his feet. LVN F said Resident #1's feet were a reddish/blue color and more swollen when she did the dressing changes approximately 2 weeks ago. During an interview on 3/31/2023 at 2:55 p.m. the SW said she had called the vascular specialist's office approximately 2 weeks ago. The SW said the vascular specialist's office said the were booked and short-handed. During an interview on 3/31/2023 at 2:56 p.m. the ADCO said the facility had asked the primary care physician's office to send a referral for Resident #1 to the vascular specialist. The ADCO said the vascular specialist's office had said the referral had to come from the primary care physician's office. The ADCO said she had called the vascular specialist's office to find out what information they needed for a referral and had not received a call back. The ADCO said Resident #1's right lower extremity had worsened over the past 2 weeks. The ADCO said Resident #1 was sent to the emergency room so they would be taken seriously. During an interview on 3/31/23 at 3:32 pm the Wound Care Nurse said she did not know if a referral was sent to the vascular specialist's office for Resident #1. The Wound Care Nurse said the DCO was supposed to talk to the SW regarding the referral for Resident #1 to the vascular specialist. The Wound care nurse said the nurse practitioner said the physician's office did not send referrals and that the facility's SW needed to send the referral to the vascular specialist for Resident #1. The Wound Care Nurse said Resident #1's right leg had significantly worsened over the past month. The Wound Care Nurse said Resident #1 was placed on antibiotics for the wounds to his right toes versus being sent out to the hospital. The Wound Care Nurse said Resident #1 was seen by the wound care nurse practitioner every Thursday at the facility. The Wound Care Nurse said Resident #1 did not have any discoloration to his legs but had pitting edema to both legs. The Wound Care Nurse said Resident #1's toes had worsened over the past month. During an interview on 4/03/2023 at 3:47 p.m. the primary care physician said he was informed of the referral for Resident #1 not being sent to the vascular specialist on 3/28/2023. The primary care physician said there was no way to know if Resident #1 had gotten into the vascular specialist if it would have prevented such an advanced right leg amputation. The primary care physician said he was aware of the wounds on Resident #1's toes. The primary care physician said he felt Resident #1 needed a referral to the vascular specialist due to the wounds on his right toes. (continued on next page)

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	675602	A. Building B. Wing	04/06/2023

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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/03/2023 time unknown the wound care nurse practitioner said she had seen Resident #1 a week and half ago. The wound care nurse practitioner said she was not aware of any of the issues with Resident #1's right foot/toes at the time or the infections. The wound care nurse practitioner said she did not remember any redness or signs of infections to Resident #1's right toes. The wound care nurse practitioner said Resident #1's right foot did not have a pulse. The wound care nurse practitioner said she did not think Resident #1 needed to go to the hospital, but Resident #1 did need a vascular consult During an interview on 4/04/2023 at 1:45 p.m. the SW said she handled referrals to mobile optometry, podiatry, hearing, and dental services. The SW said she had never done a referral to a physician or specialist. The SW said she was told by the nursing staff referrals to a physician or specialist was supposed to come from the primary care physician. The SW said she sometimes made appointments/referred residents for optometry, podiatry, hearing, and dental services in the community. The SW said she had never been trained on sending a referral to a physician or specialist. During an interview on 4/04/23 at 1:52 p.m. the ADCO said the facility did not have a process for sending referral to physicians or specialists. The ADCO said the DCO had told her it was the primary care physician's responsibility to send referrals. During an interview on 04/04/23 at 1:54 p.m. the DCO said the physician/Medical Director told the facility they did not send referrals. The DCO said the facility cannot make referrals. The DCO said there was not a process in place for making/sending referrals. During an interview on 04/04/23 at 2:00 p.m. the EDO said for referrals the charge nurse or SW would make the appointments. The EDO said the facility did not have a policy regarding referrals to outside physicians or specialists. The EDO said if the physician/Medical Director wrote an order for a resident to see an outside physician/specialist the facility would call to start the process of getting the appointment made. Record review of the facility's Change in Condition or Status policy last revised May 2017 indicated, .The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . significant change in the resident's physical/emotional/mental condition .need to transfer the resident to a hospital or treatment center . The EDO was notified on 4/04/2023 at 3:20 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The EDO was provided the Immediate Jeopardy template on 4/04/2023 at 3:22 p.m. The facility's Plan of Removal was accepted on 4/06/2023 at 8:28 a.m. and included: In Response to the facility failure to have a referral system or policy in place, the Administrator immediately created and implemented a referral policy on 4-4-23 to ensure that no additional residents are affected by poor quality of care. To ensure no other residents were affected by the facility failure of not having a referral system in place, the Director of Clinical Operations or Assistant Director of Clinical Operations has completed a review all orders on 4-4-23, for any orders requiring physician and or specialist referrals to ensure referrals are handled in a timely manner. No additional missed referrals were found. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In Response to the facility failure to follow up with physician, the Medical Director, Licensed Nurses, Social Worker and wound care specialist will be provided in-service education related to the referral process policy. Inservice: Physician referral process for sending residents to a specialist or outside physician services by obtaining the Medical Director's referral order beginning on 4-4-23 to be completed by 04-4-23, by the Administrator or Assistant Director of Nurse's which includes: Referral Policy: 1. Upon receiving directions or recommendations from a provider or nurse practitioner, whether a physician or nurse practitioner, the charge nurse is to contact the Medical Director immediately and enter an order in PCC. 2. The charge Nurse to notify the Director of Nurses and/or the Assistant Director of Nurses and the Social Worker of the referral. 3. Social Worker to call in referral order, confirm insurance, obtain doctor signature on forms if needed and make appointment with Specialist and arrange for appropriate transportation. 4. Administrator to be notified if referrals are refused or denied by physician or Medical Director immediately with the reason for the denial to determine if the resident needs to be sent out to hospital for further evaluation. If it has been found the resident does not need immediate referral, the Director of Nurses will continue to monitor during daily clinical meetings with charge nurses and treatment nurses for change of condition. If a change of condition is found the physician is to be immediately notified. 5. Newly hired nurses will receive in-service from the Assist Director of Nurses regarding physician referral during orientation process, and to be included in the nurse's information book or Brain Book at nurse's station. In response to the facility failure to send a referral to the vascular specialist, the Director of Nurses, Assistant Director of Nurses and Social Worker will be provided in service to obtain the necessary information from the specialist's office, including vascular specialist, for the referral requirements needed from the physician and obtain the required signature's or orders to accommodate the requirements for the specialist to ensure there are no delays in resident's delay in care. In-service provided to Director of Nurses, Assistant Director of Nurses, and Social Worker 04/04/23 by Administrator to be completed by 04/04/23. Validation/Monitoring Tools Director of Clinical Operations or Designee will validate staff knowledge base through random questioning. Director of Clinical Operations or designee will review any referral orders documented by reviewing orders in daily stand up meeting and clinical meetings to ensure appointments are being made, beginning 4-4-21. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Director of Clinical Operations or designee has called to follow up with Resident affected by the Failure of Quality of Care 4-4-23. Information obtained was that the resident received an above knee amputation and is being discharged to another skilled nursing facility for rehab. On 4/06/2023 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of the chart audits for residents who had been referred to outside providers in March 2023 was performed with no other issues noted. Record review of the facility's undated Referral Policy was performed. The Referral Policy indicated the facility's newly implemented steps in ensuring referrals were made to outside providers in a timely manner. Record review of the facility's Brain Book located at the nurse's station indicated the referral policy had been added into the book and was available to the nursing staff at all times for reference. Record review and signature verification was performed on in-services dated 3/30/23 through 4/13/23 regarding the facility's Referral Policy Interviews of staff on 4/04/2023 between 11:03 a.m. and 11:48 a.m. (LVN A, RN B, LVN C, RN D, RN E, ADCO, LVN F, SW, MDS nurse, Wound Care Nurse, and DON) were performed. During the interviews staff were able to correctly identify the process for referrals per the facility's Referral Policy. Interview with the Medical Director and nurse practitioner on 4/04/23 between 11:38 a.m. and 11:41 a.m. regarding the facility's referral policy indicated they had received and agreed with facility's Referral Policy. Both the Medical Director and nurse practitioner said this policy would help ensure residents received appointments and were seen by outside providers and specialists On 4/06/2023 at 11:51 a.m., the EDO was informed the IJ was removed; however, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 1 foyer and 3 (Room #'s 101, 108, and 113) of 15 resident rooms on hall 100 reviewed. The facility did not repair the leak or the water damage on the ceiling of the foyer. The facility did not repair or replace the damaged ceiling in Room #'s 101, 108, and 113). These failures could place the census of 42 residents at risk of living and working in an unsafe, unsanitary and uncomfortable environment. Findings included: During an observation on 7/10/23 at 7:45 a.m., the foyer had a large trash can placed in the middle of the floor with 3 bath towels around it. No leaking from the roof was observed at that time. The ceiling had significant water damage, approximately 6-7 feet long with open areas. It was not raining outside but there had been a recent rain and the outdoor pavement was wet. There were water puddles in the parking lot. During an observation on 7/10/23 at 9:10 a.m., the trash can and the 3 bath towels had been moved out of the foyer floor. The floor was not wet. During an interview on 7/10/23 at 9:40 a.m., the Administrator said they had been patching the roof but it still leaked. She said there were 3 rooms they had to move residents out of because of water damage. She said they leased the building and the owner refused to fix the leaks or water damage. She said the facility needed a new roof. She said someone from Corporate assessed the damage at some point and said it was not dangerous. During an interview on 7/10/23 at 10:04 a.m., the Administrator said the leak in the foyer had been there before she got to the facility in August of 2022. She said the foyer ceiling leaked with heavy rain. The DON said the leak in the foyer ceiling had been there before he got there in November of 2022. She said if the rain outside was really heavy the trash can may have up to 1 inch of water in it. The Administrator said different companies had tried to repair the foyer leak but it was not able to be fixed by patching it. The Administrator said the crack in the foyer ceiling was approximately 7 feet long but only a small portion of it was open. She said there used to be tape on the seam but it came off last month. During an interview on 7/10/23 at 10:06 a.m., the SW said she had been at the facility since November of 2022 and the leak in the foyer had been here that long at least. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/10/23 at 10:08 a.m., with the Administrator took this surveyor down hall 100. We walked into room [ROOM NUMBER]. There was no resident residing in the room. She observed the ceiling and said there was three 6-foot-long stains on the ceiling and the ceiling was flaking. She said there were also other water spots on the ceiling. The stains did not look wet. She said water did not leak into the room floor when it rained. The Administrator observed room [ROOM NUMBER]. There was no resident residing in the room. She observed the ceiling and said there were water stains around the light on the ceiling along with other 3-4-foot linear areas of water stains. She said water did not leak into the room from the ceiling when it rained. She walked into room [ROOM NUMBER]. There was no resident residing in the room. She said the ceiling was flaking from water damage. She said some of the ceiling had been repaired. The Administrator said there was a 2-foot circular area of the ceiling (popcorn texture type) missing and the sheet rock was showing. She said there was also a 2-foot water damaged area, linear area along the ceiling that went into the outside wall. She said there were also several other water spots/damage on the ceiling in room [ROOM NUMBER]. She said the ceiling in room [ROOM NUMBER] did not leak into the room when it rained. She said they had moved the residents out of rooms [ROOM NUMBER] due to the water damage. She said residents would not go into those rooms until the water damage was repaired. During an interview on 7/10/23 at 10:16 a.m., CNA A said she had worked at the facility for approximately 7 years. She said the leak in the foyer had been there about a year. She said the ceiling in the foyer leaks when it rains hard. She said rooms [ROOM NUMBER] have water damage but they do not leak. CNA A said the water damage in those rooms had been there about a year. She said there were no residents in those rooms. She said maintenance had repaired the foyer ceiling a few times and it would quit leaking but it always started leaking again. She said staff put a trash can under the leak and towels around it. She said she did not know how much it leaked or how much water was usually in the trash can after a rain. During an interview on 7/10/23 at 10:18 a.m., the Director of Resident Accounts said she had worked at the facility over 2.5 years. She said the ceiling in the foyer had leaked off and on the whole time she had worked at the facility She said people had tried to fix it but could not. She said staff put a trash can under the foyer ceiling when it was raining. She said depending on how hard it rained the trash can could have up to 1 inch of water in it. She said with light rain there would be no accumulation in the trash can. The Director of Resident Accounts said when it rained heavily you could see the ceiling was wet in the foyer. She said some rooms on 100 hall, rooms [ROOM NUMBER] had water damage but no residents were in them. She said the ceilings in those rooms did not leak into the floor. She said companies had come in to fix those too but were not able to fix them. During an observation on 7/10/23 at 10:23 a.m., it was raining heavy outside. Water was leaking from the foyer ceiling into the floor. The water leaking was a steady drip and made a circular wet area in the floor about 10 inches in diameter. Staff went to get the trash can and the bath towels. During an interview on 7/10/23 at 10:26 a.m., the Maintenance Supervisor said he was new and was just beginning his third week at the facility. He said fixing the roof or ceiling was out of his scope. He said Corporate handled the roof and repairs. He said no one had tried to fix the roof since he had worked at the facility. The Maintenance Supervisor said there was usually not that much water in the trash can. He said the accumulation might be 1/2 to 1 inch with heavy rain. During an interview and record review on 7/10/23 at 10:34 a.m., the Administrator provided an email from the [NAME] President of Plant Operations that indicated: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.I am writing to address the recent concern regarding the leaky roof at [facility name]. While it is imperative to address any building maintenance issues, I would like to assure you that the current leak does not pose any immediate danger to residents, staff, or the overall structure of the building. I assessed the situation and there are no indications of compromised structural integrity. The building's frame work remains stable and secure. During an interview on 7/10/23 at 10:36 a.m., Resident #1 said as much as they charge them to stay there, they should fix the leak. He said he was not upset; it was just the principle of the thing. During an interview on 7/10/23 at 10:38 a.m., CNA B said the foyer had leaked since November of 2022 when she started to work at the facility. She said no residents had complained about it. She said a couple of rooms had water damage on 100 hall but water did not leak into the rooms. She said she thought they had tried to fix the water damage and leak in the foyer but she did not really remember. During an interview on 7/10/23 at 10:40 a.m., Resident #3 said she had been at the facility for 2 years and the foyer had always leaked. Resident #2 said she did not understand why they did not get it fixed. Resident #2 and Resident #3 were not upset but did not understand why it had not been repaired since it had been going on for so long. Record review of A Quality of Life - Homelike Environment Policy dated May 2017 provided by the Administrator indicated: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible . 2.The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting .