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	09/15/2022

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observations, interviews and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 15 residents (Resident #11) reviewed for accidents The facility failed to ensure Resident #11 was properly secured in his wheelchair during transport resulting in the Resident #11 coming out of his wheelchair and having bilateral femur fractures and a clavicle fracture. This was determined to be past a non-compliance Immediate Jeopardy (IJ) with actual harm due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. The Administrator was notified of the past non-compliance Immediate Jeopardy (IJ) on 9/13/22 at 4:22 p.m. This failure could place residents at risk for injury/death from a vehicle accident and decreased quality of life. Findings Include: 1. Record review of the face sheet dated 9/15/22 indicated Resident #11 was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including fracture of the left femur, cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), fracture of the left clavicle, fracture of the right femur, Parkinson's (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), and muscle weakness. Record review of the comprehensive MDS dated [DATE] indicated Resident #11 was usually understood by others and usually understood others. The MDS indicated Resident #11 had a BIMS assessment had not been completed. The MDS indicated Resident #11 required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS indicated Resident #11 required limited assistance with eating. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the care plan last revised on 5/31/22 indicated Resident #11 was at risk for falls related to diagnoses of cerebral palsy, Parkinson's disease, paraplegia, and unspecified convulsions. The care plan indicated Resident #11 had limited physical mobility related to cerebral palsy, Parkinson's disease, and paraplegia with interventions including resident had a manual wheelchair and a motorized wheelchair special made for his body/contractures. The care plan indicated Resident #11 had alteration in mobility related to sustained multiple fractures (bilateral femurs (upper leg bone) and left clavicle (collar bone)). Record review of the provider investigation report dated 5/31/22 indicated Resident #11 and Resident #15 were being transported by the facility van and accompanied by facility staff when Resident #11 fell out of his wheelchair when the vehicle stopped. The provider investigation report indicted Resident #11 was transferred from the scene of the incident to the emergency department by ambulance for assessment. The provider investigation report indicated the facility was notified by the hospital on 5/31/22 Resident #11 had a fracture to both lower extremities that would require surgery and may have had additional injuries as some results were still pending. The provider investigation report indicated CNA R and the former SW were found negligent in their actions when failing to properly secure Resident #11 and his wheelchair after performing a demonstration of how the Resident #11 and his wheelchair were secured prior to the accident. The provider investigation report indicated CNA R and the former SW were both terminated following the investigation by the facility. Record review of an in-service dated 5/31/22 indicated staff had been in-serviced on driver and vehicle safety, driver and vehicle safety policy, and hands on demonstration. Record review of Resident #15's witness statement dated 6/01/22 indicated Resident #15 said she and Resident #11 were not buckled in securely during the transport on 5/31/22. Resident #15 said in her witness statement the driver was reckless and hit the brakes hard. Resident #15 said in her witness statement she had to brace herself when the van came to a stop and Resident #11 came out of his wheelchair. Resident #15 said on the trip from the facility to her appointment her wheelchair had not been strapped down and that only the wheelchair break had been applied. Record review of an action plan agenda dated 6/1/22 indicated the facility recognized an issue/concern of securing and transporting residents. The action plan agenda had a measurable goal of no resident would be injured during transport related to loading or securing mechanisms. The action plan agenda included the following interventions: All staff that would be allowed to operate the facility van had performed a return demonstration on loading residents who use wheelchairs and securing residents in wheelchairs. All new employees who would operate the facility van, on the skill check off, including loading riders who use wheelchairs, power chairs vs wheelchair, and procedures for securing wheelchairs. Director of Maintenance and/or any trained administrative designee will in-service and train all staff that would provide transportation. Record review of CNA R employee file indicated she was terminated from the facility on 6/8/22. Record review of the former SW's employee file indicated she was terminated from the facility on 6/8/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CNA C's employee file it indicated had a New Driver Form including DL number signed by the administrator on 8/04/22, had signed acknowledgement and consent agreement company or rental vehicle policy on 8/04/22, had Vehicle Safety Acknowledgement signed 8/04/22, and a Securing Resident in Van Competency signed by the Administrator. Record review of the Maintenance Supervisor's employee file indicated New Driver Form including DL number signed by the administrator on 8/04/22, had signed acknowledgement and consent agreement company or rental vehicle policy on 8/04/22, had Vehicle Safety Acknowledgement signed 8/04/22, and a Securing Resident in Van Competency signed by the Administrator. During an interview on 9/12/22 at 10:49 a.m. Resident #11 said on 5/31/22 he had gone to the surgical center and was transported by the facility van. Resident #11 said he went to the surgical center for pain management. Resident #11 said he was picked up by the facility van. Resident #11 said the driver of the facility van was a transportation aide in training. Resident #11 said there was stuff on the floor of facility van. Resident #11 said the transportation aides had to move things around to put him on the facility van. Resident #11 said the transportation aides only secured his wheelchair with two straps on the left-hand side. Resident #11 said he did not have a strap across his body (shoulder harness or lap belt). Resident #11 said the transportation aide came to abrupt stop and resident flipped out of his WC. Resident #11 said he was lying in the floor of the bus. Resident #11 said he insisted the facility staff call the for transport to the emergency department. Resident #11 said he was transferred to the emergency department and test results revealed he had bilateral femur fractures and a clavicle fracture. During an interview on 9/12/22 at 12:19 pm the BOM said the former SW had transported residents in the facility van prior to the accident involving Resident #11. She said the former SW was training new transportation drivers at the time of the accident involving Resident #11. During an interview on 9/12/22 at 3:08 p.m. Resident #15 said she remembered the incident on 5/31/22 involving Resident #11 getting injured on the facility van. Resident #15 said they were being transported in the facility van and the transportation aide stopped too fast. Resident #15 said Resident #11's wheelchair was not locked down properly and he came out of the wheelchair. Resident #15 said she was pulled forward by the sudden stop, but her wheelchair did not move and she did not come out of her wheelchair. During an interview and observation on 9/13/22 at 9:00 a.m. CNA, C demonstrated securing a wheelchair in the facility van. CNA C secured the wheelchair with 5 straps attached to the floor and a shoulder strap and lap belt over where the resident would be sitting in the wheelchair. CNA C said she had been working at the facility for about 1 month. CNA C said she was trained on facility transport by the Maintenance Supervisor. The van was observed to have accommodations for one wheelchair to be secured in the facility van. CNA C said she had been trained to only transport one resident in a wheelchair at a time. During an interview on 9/13/22 at 9:46 am the Administrator said she expected only one resident in a wheelchair to be transported at a time. The Administrator said only one resident in a wheelchair should be transported due to the van only being equipped to safely secure one wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/13/22 at 9:49 a.m. the former SW said she was not training the transport person. The former SW said she was in the van with the transport person when she picked up the Resident #11. The former SW said she had assisted in transporting residents. The former SW said she had not been trained on transporting residents. The former SW said she had transported residents on her own and with CNA's. The former SW said there were 2 residents in the van both were in wheelchairs at the time of the accident. The former SW said she did not know how many wheelchairs the van could safely secure. The former SW said that was the first time 2 residents in wheelchairs had been transported at the same time. During an interview on 9/13/22 at 10:50 a.m. the Maintenance Supervisor said he trained the new certified transportation aide. The Maintenance Supervisor said he was trained by the Administrator. The Maintenance Supervisor said he watched videos and performed demonstrations to become trained. The Maintenance Supervisor said when he trains a new transportation aide they watched the required videos and then performed safety demonstrations on securing residents who were in wheelchairs and who ambulate, using the lift, securing loose items, and driving the facility van. During an interview on 9/13/22 at 10:52 a.m. the former DON said it was her first week working in the facility when the accident occurred on 5/31/22. The former DON said she was notified of the accident by the former Administrator. The former DON said Resident #11 was sent to the ER after the accident. The former DON said Resident #11 suffered a clavicle fracture and bilateral femur fractures. The former DON said there had been 2 residents on the van in wheelchairs when the accident occurred. The former DON said she thought the van was equipped to transport 2 residents in a wheelchair at the same time. The former DON said the former SW and CNA R were not trained on transporting residents. The former DON said after the incident the former Administrator, the former SW, CNA R, and she were trained regarding transporting residents by the corporate nurses. During an interview on 9/13/22 at 11:30 a.m. the former Administrator said the former SW was training CNA R on transporting. The former Administrator said he had been led to believe the former SW had been trained on transports. The former Administrator said on 5/30/22 CNA R shadowed the former SW during resident transports. The former Administrator said on 5/31/22 CNA R return demonstrated back to the former SW the proper way to transport residents. The former Administrator said 2 residents in wheelchairs had been transported together at the time of the accident. The former Administrator said the van was equipped to secure 2 residents in wheelchairs at the same time. The former Administrator said there was adequate equipment to secure both residents when the accident occurred. The former Administrator said Resident #11 sustained injuries including 2 broken femurs and a broken clavicle. The former Administrator said the Maintenance Supervisor was trained along with other staff members a day or two after the incident. The former Administrator said the training was performed by corporate nurses. During an observation on 9/13/22 at 3:15 p.m. the surveyor watched the following training videos provided by the facility: SURE-LOK Wheelchair Restraints by NW Bus Sales Commercial Wheelchair Operators Video Wheelchair Lift Overview Video (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All videos observed by the survey gave instruction for properly loading and unloading residents via the lift on the facility van and properly securing a resident in a wheelchair for transport. Record review of the facility's undated Driver and Vehicle Safety Manual indicated, .The objective of this policy is to implement safe driving policies and practices so that the following goals are met .No employee or resident injuries in or around a vehicle .Residents are properly secured at all times .Employees droving the company vehicle shall also: Know how to safely load and unload residents/passengers and properly secure wheelchairs and other equipment if responsible for transporting residents .Team members who drive the company vehicle for residents must watch the following videos: SURE-LOK Wheelchair Restraints by NW Bus Sales, Commercial Wheelchair Operators Video, and Wheelchair Lift Overview Video .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46061 Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 3 of 15 residents reviewed for palatable food. (Residents #11, #10, and #19) The facility failed to provide palatable food to Residents #11, #10 and #19. This failure could place residents who eat food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. Findings include: 1. Record Review of Resident #11's admission record (no date) indicated he was a [AGE] year-old male admitted on [DATE] with a diagnosis of cerebral palsy (impaired muscle coordination), type 2 diabetes (blood sugar disorder) and paralytic gait (paralysis). Record Review of Resident #11's MDS indicated that he had a BIMS score of 14 indicating he was cognitively intact. The assessment did not indicate what diet was required for Resident #11. Record Review of Resident #11's orders indicated that he has on a carb controlled/no added salt diet with regular texture. Diet also includes large meat and egg portions and no bell peppers. Record Review of Resident #11's care plan (no date) indicated he was on a carb-controlled diet, NAS with regular texture. Interventions are large meat and egg portions, monitor and record meals, and explaining to resident the importance of maintaining the diet ordered. During interview on 9/12//2022 at 10:49 a.m., Resident #11 stated, the food stinks and is served cold. 2.Record Review of Resident #10's admission record (no date) indicated she was a [AGE] year-old female with a diagnosis of depression, absence of right leg below the knee and muscle weakness. Record Review of Resident #10's MDS dated [DATE] indicated that she had a BIMS score of 15 indicating she was cognitively intact. The assessment did not indicate what diet was required for Resident #10. Record Review of Resident #10's orders dated 9/2/2022 indicated that she was on a low cholesterol low fat diet with regular texture. Record Review of Resident #10's care plan (no date, but target date was 9/23/2022) indicated she was on a regular diet. Interventions to monitor and document intake, offer snacks within diet, serve diet as ordered and offer substitute if less than 50%eaten and Dietary Manager to monitor/discuss food preferences. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 9/13/22 at 9:40 a.m. with Resident #10, Resident #10 was given her lunch and stated the chicken was hard and there was not enough meat. The surveyor retrieved the ADM to look at Resident #10's tray. Resident #10 complained about the chicken and requested fries and chicken strips, the ADM took a fork and touched the chicken and stated, it is hard. 3. Record Review of Resident #19's admission record (no date) indicated he was a [AGE] year-old male admitted on [DATE] with a diagnosis of dementia, muscle weakness and hypertension (high blood pressure). Record Review of Resident #19's MDS dated [DATE] indicated a BIMS of 12 for mildly impaired. The assessment did not indicate what diet was required for Resident #19. Record Review of Resident #19's orders dated 10/28/2017 indicated he was on a regular diet. Record Review of Resident #19's care plan indicated he was on a regular diet. The Interventions included to monitor and document intake, offer snacks within diet, serve diet as ordered and offer substitute if less than 50% is eaten, dietary manager to monitor/discuss food preferences and weight monthly and PRN (no date but target date 11/2/2022). During an interview on 9/12/22 at 12:10 p.m. with Resident #19, Resident #19 stated the food at the facility was, raggedy . Resident #19 stated, the food was cold and did not taste good. During an observation and interview on 9/13/2022 at 1:42 p.m., a lunch tray was sampled with the Dietary Manager. The sample tray consisted of pinto beans, turnip greens, BBQ chicken, a roll and cheesecake. The Dietary Manager agreed the pinto beans were cold, the greens were bland, the chicken was cold, and the cheesecake was not cold. During an interview on 9/15/22 at 2:34 p.m. with the ADM, the ADM stated that dietary is responsible for checking the food and she is responsible for making sure dietary is doing their job. The ADM stated some of the foods ordered have been on back order with the current place they are ordering food from and they cannot get some foods at the facility. During an interview on 9/15/22 at 2:34 p.m., the Administrator said they were unable to find a facility policy regarding palatable meal trays.