Printed: 09/01/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIE Focused Care of Gilmer	ER	STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	etc.) that affect the resident.  **NOTE- TERMS IN BRACKETS IN BRAC	ysician Resident #1 was not receiving ysician Resident #1 did not receive her back pain. ysician Resident #1 had pressure wou	ONFIDENTIALITY** 41656  orm the physician when there was a esidents whose records were her indefinitely prescribed antibiotic revertebral x-ray that was ordered and to her feet and a surgical p.m. While the IJ was removed on y of actual harm that is not need to evaluate the effectiveness and resulted in death.  Indicated she was [AGE] years old, he had diagnoses including addition causing extreme mood

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 675602

If continuation sheet Page 1 of 29

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	lumbar surgery in May 2022, but di readmitted to the hospital in July 20 MRSA (a bacteria that is resistant ton antibiotics. After a few more relanother surgery to stabilize her spii indicated she was on doxycycline rindicate she was to follow up with a Record review of Resident #1's bashad no wounds or skin alterations.  Record review of Resident #1's advision, could understand and was usymptoms not directed at others from environment of others. She was tot dressing and toileting. She utilized days prior to admission, being at riswounds. The MDS also did not indimarked as surgical incision, surgical included treating per physician ordereat pain per physician ordereat pain per physician orders, and Record review of Resident #1's order three areas to her lumbar spine and dressed once a day. Orders for capsule by mouth twice a day (an a Record review of Resident #1's order 10/28/22 included the following order doxycycline monohydrate 100mg and date of 10/03/22.  *doxycycline hyclate 100mg tablet doxycycline monohydrate 100mg and 10/26/22.	spital history and physical, with an admid not give the exact date. Her wound be 022 for removal of hardware in her spir to most antibiotics and causes hard to thospitalization s, she was diagnosed when. An active drug list sent to the facility monohydrate 100mg and was to receive any physician and did not address would seline care plan, completed on 09/27/2 mission MDS, dated [DATE], indicated understood by others, and had intact commod 1 to 3 days of the look back period at ally dependent on two staff members who as wheelchair for mobility. She was does for pressure sores, but not having an icate she had received antibiotics withing the plan, with an admitted [DATE], indicated she had received antibiotics withing the plan, with an admitted [DATE], indicated assess skin weekly and record finding the summary report, indicated active on to be cleansed with normal saline, dries or the areas were entered on 10/27/22. antibiotic) was entered on 10/21/22 and the summary report, indicated discontinuous der summary report, indicated discontinuous entered and summary report, indicated and summary ente	secame infected, and she was be. Blood cultures were positive for treat infections) and she was placed with osteomyelitis and underwent by from the hospital on 09/23/22, et it long term. The orders did not and care or monitoring of wounds.  2 by the interim-DON indicated she she had adequate hearing and organition. She exhibited behavioral and she disrupted the living with bed mobility, transfers, walking, rumented as not having surgery 100 my pressure sores or surgical in the first 7 days of her stay.  The skin conditions were estasis/venous areas. Interventions down or infection, monitor for and gs in the clinical record.  The ders as of 11/07/22 included orders and the did a start date of 10/26/22.  The ders as of 10/01/22 through the did and ended on 10/21/22 and an ended and ended on 10/21/22.  The start date of 10/21/22 with a start date of

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NAME OF PROVIDER OR SUPPLI	FD	STREET ADDRESS, CITY, STATE, ZI	P CODE
Focused Care of Gilmer	LK	623 Hwy 155n	F CODE
r could care or climer		Gilmer, TX 75644	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0580	Record review of Resident #1's Se through 09/01/22 to 09/30/22.	ptember MAR, indicated she did not red	ceive doxycycline monohydrate
Level of Harm - Immediate jeopardy to resident health or safety	Record review of Resident #1's Oc 100mg capsules on 10/26/22 at 9 p	tober MAR, indicated she began receiv o.m.	ring doxycycline monohydrate
Residents Affected - Few	Record review on 11/03/22 at 3:00 #1's doxycycline being destroyed w	p.m. of the facility drug destruction log vithin the past month.	revealed no record of Resident
	she had a surgical incision to her u	mission assessment, dated 09/27/22 ar pper-mid vertebrae, a pressure wound assessment did not indicate the size or	to the outer side of her left foot and
	Record review of Resident #1's weekly skin assessment, dated 09/27/22 and completed she had a post-surgical site to her mid lumbar with 2 sutures noted, and a small area to wound was covered with a dressing and tape. The two wounds to her left foot were coved dressing. The assessment did not indicate the size or condition of the wounds.		
		ctronic chart throughout the duration of her weekly skin assessments during he	
	was just admitted to the facility from resident and wrote see assessmen	ritten by LVN A and dated 09/27/22 at an the hospital. LVN A completed a head ts. The resident was described as alert te did not indicate the resident having a	d-to-toe assessment on the and oriented, in no pain, and her
		t dated 09/27/22 indicated Resident #1 s, high blood pressure, low thyroid, a fo incision or the wounds to her feet.	
	Record review of the 24-hour repor The night shift indicated she had on	rt dated 09/29/22 indicated Resident #1 steomyelitis of the vertebra.	yelled out all shift on the day shift.
		ritten by LVN A and dated 09/30/22 at 3 by coughing. A COVID test was conduc autions were to be initiated.	
	Record review of the 24-hour repor	t dated 09/30/22 revealed no report fou	und.
	Record review of the 24-hour repor changed rooms to 314.	t dated 10/01/22, during Resident #1's	COVID isolation, indicated she
		ekly skin assessment, dated 10/04/22 ands, pressure wounds, or skin alteration	
	(continued on next page)		

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F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Record review of a nurse's note, written by agency LVN C and dated 10/08/22 at 1:10 p.m., indicated Resident #1 was yelling out, had increased agitation/anxiety, was throwing things, and reporting pain to her lower back. The physician gave an order to x-ray her lumbar spine related to severe pain.  Record review of the 24-hour report dated 10/08/22, during Resident #1's COVID isolation, indicated she was to receive an x-ray to the lumbar spine on the day shift. She continued to yell out constantly on the night.			
	Record review of the 24-hour report were still awaiting the x-ray to her s	t dated 10/09/22, during Resident #1's spine.	COVID isolation, indicated they	
	Record review of the 24-hour report reports except for 10/01/22, 10/08/	t book on 11/03/22 at 4:00 p.m., revea 22 and 10/09/22.	led no other COVID wing 24-hour	
	Record review of a nurse's note, written by agency LVN D and dated 10/10/22 at 3:26 a.m Resident #1 was continuing to yell out, banging on the walls, and yelling for staff to help he the resident was still awaiting the x-ray to her lumbar spine related to frequent pain.			
	Record review of Resident #1's physician consult note, with an admitted [DATE], indicated she admitted for hospice and was to continue doxycycline hyclate 100mg twice a day upon discharge and was to be on hospice services. The ID Physician who had previously treated Resident #1 indicated in her progress notes on 10/20/22, that the resident had discharged from the hospital on antibiotics with instructions to continue them indefinitely due to recurrent back infections. The physician also indicated the resident had gone off the antibiotics while residing in the facility. The paperwork did not indicate the condition of the resident's wounds, only wound care orders, and the resident's family wanted her to begin hospice care.			
Record review of a nurse's note, written by LVN A and dated was readmitted to the facility on hospice services. She was do the dehisced wound over her lumbar vertebrae, and two oper			naving discoloration to her heels,	
	indicated she had a surgical incisio	admission assessment, dated 10/21/22 on to her upper-mid vertebrae, a pressulvis), and vascular wounds to her left at the wounds.	re wound to her sacrum (the base	
	problems, moderately impaired decorporately others. She was totally dependent	charge MDS, dated [DATE], indicated s cision-making skills, and continued to e on staff for all ADLs, except for eating, having skin concerns or wounds, and	xhibit behaviors not directed at which required only supervision.	
	(continued on next page)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		on)
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	During an interview on 11/01/22 at 2:10 p.m. with RN F and LVN A, RN F said she had issues earlier iday, on 11/01/22, while putting in orders for doxycycline hyclate for a different resident. She said the pharmacy automatically kicked out the order and wanted to switch it to doxycycline monohydrate inste She said she had been looking for the order and realized it was no longer there, then she realized the pharmacy had sent the new order for her to confirm. She said because LVN A was an LVN, she could confirm orders, only RNs could. She said LVN A would have put in the doxycycline order and then whorder change confirmation came in, the DON would have to approve it since she was an RN. LVN A so Resident #1 admitted and very quickly into her stay was sent to the COVID unit. She said she did not anything was done for the resident, such as skin assessments, wound care, and medication administr. The nurses said they did not have a wound care nurse and had do their own treatments on their halls.  During an interview on 11/01/22 at 3:52 p.m. CNA E said she had worked with Resident #1 on the CO hall. She denied observing any wounds on her back because on the COVID hall the resident would so when touched and she would not turn all the way over. She said the night she found the wound on her 10/18/22, the resident had been complaining of pain from not having a bowel movement. The nurse garesident a laxative and later, the resident told the aide she had gone to the bathroom and needed to be changed. The aide went to change her, and saw the sheets were soiled and it was a very substantial amount. She said she believed the resident flet the wetness from her wound and thought it was a bow movement. She said she initially thought it was a bowel movement as well, until she rolled the resident way over and saw the wound. The wound was purple and covered by the flaps of skin due to her obes She said when she pulled the resident's skin taught, she could physically see into the wound and large amounts of drainage came out with even		rent resident. She said the xycycline monohydrate instead. there, then she realized the /N A was an LVN, she could not xycycline order and then when an ce she was an RN. LVN A said D unit. She said she did not know if re, and medication administration. where the there is a she was an the resident would scream she found the wound on her back, well movement. The nurse gave the bathroom and needed to be and it was a very substantial and and thought it was a bowel I, until she rolled the resident all the flaps of skin due to her obesity, see into the wound and large age was chunky and gritty and was VN B was unaware of the wound wound but did not find any. She said before the resident went to the after the hospital she did not know help.

(continued on next page)

During a phone interview on 11/01/22 a 4:30 p.m. agency LVN B said she had been going back and forth between days and nights. She said the 6a-2p was supposed to do most of the wound care. She said Resident #1 was obese and flabby and a skin fold on her back covered the wound. She said she had to pick up the fold and pull her skin taught, all while the resident was screaming and swinging at staff. She said the wound was pretty long because it was a surgical incision, but she did not know how long for sure. She said maybe a quarter of her spine. She said when she pulled the skin back, dark brown drainage poured out of it. She said she went back to look at the resident's chart and saw she had MRSA in her spine before she came to the facility. She said the drainage did not have an odor and the wound did not appear to be red or swollen. She said she did not remember the skin assessment she did for the resident on 10/04/22, but if she documented the resident had no wounds, she must have looked the resident over completely. She said she remembered the last time she took care of the resident, she recalled giving the resident brown and yellow pills, which would be doxycycline. She said that was right before the resident left with her family on 10/28/22.

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Focused Care of Gilmer  For Information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  Level of Harm - immediate jeopardy to resident health or safety  Residents Affected - Few  During a phone interview on 11/02/22 at 9:00 a.m. the Pharmacist said the medical director had sign, and the corporate office was usually the one that requested the therapeutic interchanges to be made whenever an order was put in for a worning medication. For exam the doctor ordered doxycycline monthydrate and staff entered doxycycline hydiate, the system would be corporate office was usually the one that requested the therapeutic interchanges and if one facility the corporate office was usually the one that requested the therapeutic interchanges and if one facility is reasons for the therapeutic interchanges, such as cost to the facility, or ensuring the correct order was followed. She said she saw in the system where the doxycycline was ordered on 0/27/22 and the sy changed it to doxycycline monthydrates pushed they sent out of biglist that day. The next of them came in on 10/21/22, they did not send any out because the refill was too soon from the last fall in the corporate office was usually with the solution of the said there were different and the said of t		IDENTIFICATION NUMBER:	A. Building	COMPLETED
F 0580  Level of Harm - Immediate jeopardy to resident health or safety to resident to resident to safety safe		ER	623 Hwy 155n	P CODE
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Bresidents Affected - Few  During a phone interview on 11/02/22 at 9:00 a.m. the Pharmacist said the medical director had sign therapeutic interchanges to be made whenever an order was put in for a wrong medication. For exant the doctor ordered doxycycline monthydrate and staff entered oxycline hydalet, the system would be doctor ordered doxycycline monthydrate and staff entered oxycline hydalet, the system would out the order for hydale and enter a new order for the monohydrate, which an RN must approve. She the corporation did it them most likely all facilities under that corporation did. She said there were differ reasons for the therapeutic interchanges, such as cost to the facility, or ensuring the correct order was followed. She said she saw in the system where the doxycycline was ordered on 09/27/22 and the system where the doxycycline was ordered on 09/27/22 and the system where the doxycycline was ordered on 09/27/22 and the system where the doxycycline was ordered on 09/27/22 and the system where the doxycycline was ordered on 09/27/22 and the system where the doxycycline was ordered on 09/27/22 and the system where the doxycycline was ordered on 09/27/22 and the system where the doxycycline was ordered on 09/27/22 and the system where the oxycycline was ordered on 09/27/22 and the system was ordered on 09/27/22 and the system where the three publications and the wanted the resident to follow up with her, but that never happened. She was unsure why a follow up happened, whether it was due to hospital error, facility error, or even family error. She said she had on the order or order the facility, but since she did not facility, or write orders there, she was not sure if the resident received the antibiotics or not.  During an interview on 11/03/22 at 2:20 p.m. LVN A said she did port the facility, she had a dressing over including the propertion of the part of the bandage because she was follow ound care had been done be resident	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
therapeutic interchanges to be made whenever an order was put in for a wrong medication. For exist the doctor ordered doxycycline monohydrate and staff entered doxycycline hyclate, the system would out the order for hyclate and enter a new order for the monohydrate, which an RN must approve. She said stept seems of the corporation did it then most likely all facilities under that corporation did. She said there were differeasons for the therapeutic interchanges, such as cost to the facility, or ensuring the correct order we followed. She said she saw in the system where the doxycycline was ordered on 09/27/22 and the sy changed it to doxycycline monohydrate capsules. She said they sent out 60 pills that day. The next of them came in on 10/21/22, they did not send any out because the refill was too soon from the last fall.  During a phone interview on 11/02/22 at 10:36 a.m. the ID physician said she was told by the family Resident #1, at the hospital, that she had not been receiving antibiotics at the facility. She said she howarded the resident to follow up with her, but that never happened. She was unsure why a follow up happened, whether it was due to hospital error, facility error, ore family error. She said she could recall what the wound looked or smelled like at the hospital when she arrived for treatment. She said give an order for the resident to have indefinite doxycycline at the facility, but since she did not go to facility, or write orders there, she was not sure if the resident received the antibiotics or not.  During an interview on 11/03/22 at 2:20 p.m. LVN A said she did part of Resident #1's admission assessment and paperwork. She said she was told in report from the discharging hospital that the reshad a surgical inicision over her spine. When the resident arrived at the facility, she had a dressing or incision. The nurse did not take off the bandage because she was told wound care had been done be resident left the hospital or anything about the resident had wound to her spine and two wounds	(X4) ID PREFIX TAG			ion)
(continued on next page)	Level of Harm - Immediate jeopardy to resident health or safety	therapeutic interchanges to be made the doctor ordered doxycycline more out the order for hyclate and enter the corporate office was usually the the corporation did it then most like reasons for the therapeutic intercharge followed. She said she saw in the schanged it to doxycycline monohyce them came in on 10/21/22, they did During a phone interview on 11/02. Resident #1, at the hospital, that sl wanted the resident to follow up with happened, whether it was due to herecall what the wound looked or sn give an order for the resident to hat facility, or write orders there, she we buring an interview on 11/03/22 at assessment and paperwork. She shad a surgical incision over her spinicision. The nurse did not take off resident left the hospital. She did a wound to her spine and two wound wound care orders they had in place physician. She said when she saw orders in for wound care, but she gorders in, and the oncoming shift or resident's doxycycline, she would hon it, then she did not administer it.  During an interview on 11/03/22 at care orders for Resident #1 and did changes for her on the COVID windover. She said she did not remember the covered that the she worked the covered that the covered the	de whenever an order was put in for a verification of the monohydrate and staff entered doxycyclina new order for the monohydrate, whice one that requested the therapeutic interest of the second of	wrong medication. For example, if e hyclate, the system would kick h an RN must approve. She said terchanges and if one facility under id. She said there were different insuring the correct order was ered on 09/27/22 and the system 60 pills that day. The next order for as too soon from the last fill date. She was told by the family and the facility. She said she had was unsure why a follow up never by error. She said she could not eved for treatment. She said she did but since she did not go to the antibiotics or not.  Resident #1's admission charging hospital that the resident cility, she had a dressing over the fund care had been done before the treatment and the end say anything about what kind of resident following up with a back, she should have put the the ADON said she would put all the he had given the initial dose of the form the end of the fill of the end of the fill one

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F 0580  Level of Harm - Immediate jeopardy to resident health or safety	had wounds while she worked the antibiotic. She said she just remem	/22 4:10 p.m. agency LVN K said she c COVID wing. She said she did not rem obered the resident yelling out and whe g and did not need anyone to come in the	ember if the resident took an n they would go in her room, she
Residents Affected - Few	aware of Resident #1 having any washe helped LVN A put the orders in with a physician, she did not put ar one followed up on getting her wou pharmacy kept kicking out the doxy out automatically and then resubmantibiotics until 10/26/22. The interiappeared the x-ray was never obtated buring a phone interview on 11/04, resident not receiving wound care doxycycline. He said he had not rexeray was not obtained. He said ha giving her the ordered antibiotics, of	4:25 p.m. with the ADON and interim-It younds to her feet but did know she had an and since she did not see any orders by in. The ADON and the interim-DON sund care or to follow up with a physiciar ycycline orders and the LVNs could not itted. They both denied knowing about im-DON said she could not find the restined.  1/22 at 10:30 a.m. Resident #1's Physiciat to her feet or her back. He was also not ceived the results of the x-ray to her back dhe known all this information, he would be the spinal x-ray, and gotten he hysician's name) and was not aware the	d a wound to her spine. She said for wound care or for following up said they were both unaware no a. They also were unaware the see the orders were being kicked the resident not receiving her ident's x-ray of her back and it an said he was not aware of the t aware of her not receiving her ick and had not been aware the ald have made sure staff were ar into the ID for follow up. He said
	had wounds anywhere on her body she did not know if the resident had the resident's lumbar spine on 10/0 resident said she had pain to her b She said she worked the 6a to 2p s She said when she came back that x-ray company to see where the re operator said the system had been message to the x-ray technician. S	/22 at 10:19 a.m. agency LVN C said signs. She said the resident would not let the dany wounds to her back. She said the 08/22 since she was complaining of pai ack but then would not let them reposit shift on 10/08/22 and then had to come to night, she saw where the x-ray result is sults were. She said when she called the out and he was not able to see anything he said the technician never came on that the x-ray technician had not come e that day.	em turn her all the way over, so e physician did order an x-ray for in to her there. She said the ion her or turn her all the way over. back to work a 10p to 6 a shift. was not received so she called the he x-ray company, the on-calling on his end but would send a her shift and she notified the 6a to
	Resident #1's back pain. She said did not remember the resident havine her of the resident having a surgical Record review of the facility's Char promptly notify the resident, his or	/22 at 3:28 p.m. LVN L denied ever being the resident was always yelling out due ing any wounds to her feet or her back. all wound to her back.  Inge in a Resident's Condition or Status her Attending Physician, and represent an and/or status (e.g., changes in level of	to her psychological issues. She She denied anyone ever notifying policy indicated, Our facility shall ative (sponsor) of changes in the
	Policy Interpretation and Implement	otation	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0580	The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): .		
Level of Harm - Immediate jeopardy to resident health or	.d. significant change in the reside	nt's physical/emotional/mental conditio	n;
safety	e. need to alter the resident's medi	cal treatment significantly; .	
Residents Affected - Few	.g. need to transfer the resident to	a hospital/treatment center; .	
	Record review of the facility's General Guidelines for Medication Administration policy indicate of regularly scheduled medication is withheld, refused, or given at a time other than the scheduler than the resident is not in the facility at a scheduled time or a started dose of an antibiotic is neededuled on the front of the MAR for that dosage administration is initialed and circled. An expendence on the reverse side of the record. If 3 consecutive doses, or in accordance with facility vital medication are withheld, refused, or not available, the physician is notified. Nursing documotification and physician response.  An Immediate Jeopardy (IJ) was identified on 11/04/22 at 12:50 p.m., due to the above failure		
	Administrator and DON were notified During an interview on 11/04/22 at	ovided on 11/04/22 at 1:09 p.m. I and Administrator, the	
	interim-DON and ADON both indications because she did not know the LVN A had documented, and so she accepted the resident's change She did not realize the resident's dapproved by her until 10/26/22. Shot realize they were popping up d 10/26/22 to approve the doxycyclin 10/26/22.	ed the resident had no skin ne said she could only go by what wounds. The interim-DON said in the system awaiting approval. since 10/21/22 and was not oped up in the system, but she did id the reason it took her until	
The following Plan of Removal submitted by the facility was accepted on 11/06/22 at the following:		11/06/22 at 8:52 a.m. and included	
	11-4-22		
	Neglect		
	building. A chart review of her phar	that did not receive her antibiotics as ormacy orders and therapeutic interchan at transpired. At the time a new Directonew antibiotic orders.	ge was completed by the Director
	(continued on next page)		

1	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER  Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	
For information on the nursing home's plan to correct this deficiency, please contained (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI		<u> </u>	agency.
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Audit of all medications compared to ensure that no other residents have Director of Clinical Operations, Assist and Treatment Nurse reviewed clinic of family and physician.  Director of Clinical Operations, Assist over the last six months to ensure for the Director of Clinical Operations, Licensed Nurses will be provided in and symptoms of worsening infection which includes:  1. Physician must be notified of any admission or re-admission via phonomal physician must be notified of any admission or re-admission or re-admi	full regulatory or LSC identifying information of current orders for all residents in house missed medications.  In this process of the control of the contr	dise was completed on 11/05/22 to clinical Reimbursement Coordinator to ensure documented notification will review all x-rays ordered with the state of the clinical of the clinical operations or designee the physician within 2 hours of the scribed no later than 3 missed the scribed no later than 3 missed the coordinate of the coordinate of the clinical operations, falls, or changes in condition attached.  The coordinate of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022	
NAME OF PROVIDER OR SUPPLII		CTREET ADDRESS CITY STATE 71	D CODE	
	ER .	STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n	PCODE	
Focused Care of Gilmer		Gilmer, TX 75644		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)	
F 0580		esignee will review records for any new		
Level of Harm - Immediate jeopardy to resident health or safety	Director of Clinical Operations or do x-rays are obtained and physician in	esignee will review all x-ray order daily notification is completed.	in the clinical meeting to ensure	
Residents Affected - Few		completed by admitting nurse to ensure nitiated within 2 hours of admission. Se		
	Change in conditions check list to be and physician notification. Beginnir	oe utilized to ensure nurse competency ng 11-7-22.	with completion of assessments	
	On 11/06/22 from 11:40 a.m. to 2:5 removal sufficiently to remove the I	50 p.m. the surveyor confirmed the facill by:	lity implemented their plan of	
	During interviews with the RN weekend supervisor, the ADON, LVN L and LVN N between 11:45 a 2:15 p.m., staff indicated they had received adequate training regarding skin assessments, antibiot antibiotic orders and use of 24 hour reports.			
		us Report dated 11/05/22 at 3:18 PM, b s being reviewed by the DON for narco		
		and 1:15 p.m. of staff who had received stated their understanding of the educ		
	residents to ensure there were no reach resident had orders and medifor pain. The interim-DON said all rwithin 2 hours. She said all nursing been trained on monitoring antibiot said nurses were to notify the DON	12:47 p.m., the interim-DON said she concern skin issues. She said she also review skin issues. She said she also review she have a skin assessment of the schedule and a staff had been trained on skin assessment is staff had been trained on skin assessment is staff had been trained on skin assessment staff had been trained on skin assessment in the schedule and any time antibiotics are ordered. She sime, until the new wound care nurse coat responsibility.	iewed all medications to ensure I she also assessed each resident ent on admission or re-admission ments. She said nurses had also I 3 days after for any reactions. She said she is the Infection Control	
		ween 12:47 p.m. and 1:15 p.m. showed or 24-hour reports were also reviewed, a		
	The facility remained out of complia	nformed the Immediate Jeopardy was ance at a severity level of actual harm to ty's need to evaluate the effectiveness	that is not immediate jeopardy and	

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIE Focused Care of Gilmer	ER	STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656  Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of 6 residents reviewed for misappropriation of property. (Resident #1)  The facility failed to prevent a diversion (misappropriation) of Resident #1's Norco 7.5mg-325mg tablets (a combined hydrocodone/acetaminophen narcotic pain reliever).  This failure could place residents at risk for decreased quality of life, misappropriation of property, and digni Findings included:  Record review of Resident #1's face sheet, with a print date of 11/07/22, indicated she was [AGE] years old admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. She had diagnoses including osteomyelitis of the lumbar (lower back) vertebra, diabetes, bipolar (a condition causing extreme mood swings from emotional highs to emotional lows), anxiety, high blood pressure, and acute (short term) kidner failure.  Record review of Resident #1's admission MDS, dated [DATE], indicated she had adequate hearing and vision, could understand and was understood by others, and had intact cognition. She exhibited behavioral symptoms not directed at others from 1 to 3 days of the look back period and she disrupted the living environment of others. She was totally dependent on two staff members with bed mobility, transfers, walkin		
	dressing and toileting. She utilized the entire 7 day look back period.  Record review of Resident #1's car conditions. The skin conditions were stasis/venous areas. Interventions findings in the clinical record.  Record review of Resident #1's orcof 11/07/22 included an order to accevery 6 hours as needed for pain.  Record review of Resident #1's Oct 10/01/22 at midnight by LVN M and 7:50 p.m. by LVN H and twice on 1 was documented on 10/04/22, 10/0000.  Record review of the facility investinurses who had worked on Reside refused to drug test and became in were negative. LVN M was terminal	a wheelchair for mobility. She was doc re plan, with an admitted [DATE], indicate re marked as surgical incision, surgical included monitoring for and treating path der summary report dated 10/01/22 to 1 dminister hydrocodone/acetaminophen tober MAR, indicated she received hyd d at 4:22 p.m. by LVN H, twice on 10/02 0/03/22 at 1:13 p.m. by RN F and 8:06	ated she had current skin wound and open lesions other than in per physician orders and record 10/30/22, indicated active orders as 7.5mg-325mg one tablet by mouth 10/222 at 12:40 a.m. by LVN H and at 10 p.m. by RN F. No administration 10/08/22, indicated all required to drug test. LVN M something. All other staff drug tests

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X) PROVIDER (75602  NAME OF PROVIDER OR SUPPLIER  Focused Care of Gilmer  STREET ADDRESS, CITY, STATE, ZIP CODE (623 Hwy 155n Gilmer, TX 75644  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency, please contact the nursing home or the state survey agency.  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency marks the preceded by full regulatory or LSC identifying information)  During an interview on 110/122 at 2:10 p.m., with RN F and LVW A, RN F said the misappropriation of Resident Affected - Few  Provided the missing medication. They both said the agency turse called the physician and wanted hint of reported the missing medication. They both denied knowing of any misappropriations before or after the one that occurred around 10/08/22.  During a phone interview on 11/04/22 at 10:30 a.m. Resident #1's physician said by ego at text on 10/08/2 from agency LVN C Isling him the resident was having uncontrolled pain, even with repositioning, He said the ren 09/09/20/20 ct 12 pills. He had to refill the precision again because the facility had not hydrocodon in the building for her and the RN supervisor had checked through the carts and the medication committee on 10/08/22 ct 12 pills. He had not refill the precision again because the facility had not hydrocodon in the building for her and the RN supervisor had checked through the carts and the medication cart to see if the medications may have been left on that cart when she transferred, he said he room just in case, even through it should not have been left to the particular state of the said had not been been with the state after the said her to ome just in case, even through it should not have been left on that cart when she transferred, he said he room just in case, even through it should not have been left to that cart when she transferred, he said he room just in case, even through it should not have been left to have an arrounce. He said he told agency LVN C to call the physician. One of t				No. 0938-0391
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 TAC  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  During an interview on 11/01/22 at 2:10 p.m., with RN F and LVN A, RN F said the misappropriation of Resident #1's medication happened over the weekend, on 10/08/22, and staff who had worked the half or browning for actual harm  Residents Affected - Few  Residents Affected - Few  Residents Affected - Few  Residents Affected - Few  During a phone interview on 11/04/22 at 10:30 a.m. Resident #1's physician and wanted him to refill the medication, to which the physician became upset, saying he had just had it refilled for that reside around \$9 ages before. They both denied knowing of any misappropriations between or after the one that occurred around 10/08/22.  During a phone interview on 11/04/22 at 10:30 a.m. Resident #1's physician said he got a text on 10/08/22 from agency LVN C letting him the resident was having uncontrolled pain, even with repositioning. He said the nurse saked for a refill to the prescription again because the facility had no hydrocodor in the building for her and the RN supervisor had checked through the carts and the medication room already.  During a phone interview on 11/04/22 at 11:09 a.m. the RN weekend supervisor said agency LVN C was agoing to give Resident #1 pain medication on 10/08/22 but realized there was no pain medication to give. The resident was no the COVID unit, so the RN weekend supervisor said segency LVN C was agoing to give Resident #1 pain medication on 10/08/22 but realized there was no pain medication room just in case, even though it should not have been there because it was no pain medication for more just in case, even though it should not have been there because it was no pain medication or more just in case, even though it should not have been there because it was not pain.  During a phone in		IDENTIFICATION NUMBER:	A. Building	COMPLETED
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.    SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)    Fo602	NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Each deficiency must be preceded by full regulatory or LSC identifying information)  Level of Harm - Minimal harm or potential for actual harm  Resident #1's medication happened over the weekend, on 10/08/22, and staff who had worked the hall or reported the missing medication. They both said the agency nurse called the physician and wanted him to refill the medication, to which the physician became upset, saying he had just had it refill the medication. To which the physician became upset, saying he had just had it refill the medication, to which the physician became upset, saying he had just had it refilled for that reside around 9 days before. They both defined knowing of any missperporpations before or after the one that occurred around 10/08/22.  During a phone interview on 11/04/22 at 10:30 a.m. Resident #1's physician said he got a text on 10/08/2 from agency, LVN C telling him the resident was having uncontrolled pain, even with repositioning. He said the nurse asked for a refill on the resident's hydrocodone. He realized he had just refilled the prescription her on 09/8/22/2 for 120 pills. He had to refill the prescription again because the fealilty had no hydrocodon in the building for her and the RN supervisor had checked through the carts and the medication room already.  During a phone interview on 11/04/22 at 11:09 a.m. the RN weekend supervisor said agency LVN C was going to give Resident #1 pain medication on 10/08/22 but realized there was no pain medication or pain the said had not find them and then looked on the third hall's medication cart. He said he did not find them and then looked on the third hall's medication cart. He said he had did not find them and then looked on the third hall's medication cart. He said he told agency LVN C to call the physician. One of the double weekend nurses called the pharmacy for them, an he called the DON, administrator and ADON. He said thot drug testing.  During a phone interview on 11/05/22 at 10:19 a.m. agency LVN C said when she started her shift, she	Focused Care of Gilmer		1	
F 0602  Level of Harm - Minimal harm or potential for actual for	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
Resident #1's medication happened over the weekend, on 10/08/22, and staff who had worked the hall ox the weekend had to be tested, but not the whole staff. LVM A said three was an agency nurse who had reported the missing medication. They both said the agency nurse called the physician and wanted him to repitle the medication, to which the physician became upset, saying he had just he for that reside around 9 days before. They both denied knowing of any missapropriations before or after the one that occurred around 10/08/22.  During a phone interview on 11/04/22 at 10:30 a.m. Resident #1's physician said he got a text on 10/08/2 from agency LVN C telling him the resident was having uncontrolled pain, even with repositioning. He said the nurse asked for a refill on the resident's hydrocodone. He realized he had just refilled the prescription her on 09/29/22 for 120 pills. He had to refill the prescription again besue the facility had no hydrocodo in the building for her and the RN supervisor had checked through the carts and the medication room already.  During a phone interview on 11/04/22 at 11:09 a.m. the RN weekend supervisor said agency LVN C was going to give Resident #1 pain medication on 10/08/22 but realized there was no pain medication to give. The resident was on the COVID unit, so the RN weekend supervisor checked the resident's previous hall medication cart to see if the medications may have been left on that cart when she transferred. He said he did not find them and then looked on the birth alls' medication cart said he checked in the medication complication and the said her checked in the medication complication cart to see if the medication and ADON. He said they started drug testing staff that afternoon and let one of the employees go when she would not consent to drug testing.  During a phone interview on 11/05/22 at 10:19 a.m. agency LVN C said when she started her shift, she counted with the off-going nurse (she did not remember the name of the nurse), and she ensured the counted with the o	(X4) ID PREFIX TAG			on)
the nurse asked for a refill on the resident's hydrocodone. He realized he had just refilled the prescription her on 09/29/22 for 120 pills. He had to refill the prescription again because the facility had no hydrocodon in the building for her and the RN supervisor had checked through the carts and the medication room already.  During a phone interview on 11/04/22 at 11:09 a.m. the RN weekend supervisor said agency LVN C was going to give Resident #1 pain medication on 10/08/22 but realized there was no pain medication to give. The resident was on the COVID unit, so the RN weekend supervisor checked the resident's previous hall medication cart to see if the medications may have been left on that cart when she transferred. He said he did not find them and then looked on the third hall's medication cart. He said he checked in the medication room just in case, even though it should not have been there because it was a narcotic. He said he he called the DON, administrator and ADON. He said they started drug testing staff that afternoon and let one of the employees go when she would not consent to drug testing.  During a phone interview on 11/05/22 at 10:19 a.m. agency LVN C said when she started her shift, she counted with the off-going nurse (she did not remember the name of the nurse), and she ensured the cou was correct for all medications that were in the lockbox. She said she and the CNA (she did not remembe who the aide was) went into Resident #1's room because she was screaming. She said they repositioned and it still did not help. She said the resident did not ask for pain medicine, but she was still going to provi some for her. She said she looked in her chart, saw she was on hydrocodone pills, and went to pull one. That was when she realized there were no hydrocodone pills, or the narcotic count sheet, so she called it physician, to which he said he had just ordered some for her recently. She said she then told the weeken supervisor. She said the RN supervisor looked all over the building and in all the o	Level of Harm - Minimal harm or potential for actual harm	Resident #1's medication happened the weekend had to be tested, but reported the missing medication. The refill the medication, to which the planning around 9 days before. They both doccurred around 10/08/22.  During a phone interview on 11/04/	d over the weekend, on 10/08/22, and a not the whole staff. LVN A said there whey both said the agency nurse called hysician became upset, saying he had enied knowing of any misappropriations 22 at 10:30 a.m. Resident #1's physician	staff who had worked the hall over was an agency nurse who had the physician and wanted him to just had it refilled for that resident is before or after the one that an said he got a text on 10/08/22
counted with the off-going nurse (she did not remember the name of the nurse), and she ensured the couwas correct for all medications that were in the lockbox. She said she and the CNA (she did not remembe who the aide was) went into Resident #1's room because she was screaming. She said they repositioned and it still did not help. She said the resident did not ask for pain medicine, but she was still going to provisome for her. She said she looked in her chart, saw she was on hydrocodone pills, and went to pull one. That was when she realized there were no hydrocodone pills, or the narcotic count sheet, so she called the physician, to which he said he had just ordered some for her recently. She said she then told the weeken supervisor. She said the RN supervisor looked all over the building and in all the other carts and did not fit the hydrocodone. She notified the physician that the RN supervisor had not found the medicine and it did appear to still be in the building. The physician refilled the prescription when she notified him that the medicine was nowhere to be found. She said when she got ready to leave, the on-coming nurse (LVN M) not show up, so she gave report and counted with the nurse that filled in. She said she explained to that nurse about the count being correct for all medications currently on the cart, but the hydrocodone was unaccounted for, and they were awaiting a delivery or to see it had already been delivered.  During a phone interview on 11/09/22 at 11:33 a.m. the ADON said LVN M was terminated after being lat her shift on 10/04/22, not calling in for her shift and then not coming in on 10/07/22 and refusing to submit a drug test over that weekend. She said she was working the night of 10/08/22 and gave Resident #1 her pain pill at 6:19 p.m.		the nurse asked for a refill on the reher on 09/29/22 for 120 pills. He had in the building for her and the RN salready.  During a phone interview on 11/04/going to give Resident #1 pain med. The resident was on the COVID un medication cart to see if the medication that the looked or room just in case, even though it shagency LVN C to call the physician he called the DON, administrator as	esident's hydrocodone. He realized he ad to refill the prescription again because upervisor had checked through the care upervisor had checked through the care upervisor had checked through the care upervisor on 10/08/22 but realized there it, so the RN weekend supervisor checked the supervisor checked the supervisor checked the third hall's medication cart. He so nould not have been there because it words to one of the double weekend nurses cand ADON. He said they started drug te	had just refilled the prescription for the the facility had no hydrocodone to and the medication room the try is a said agency LVN C was was no pain medication to give, ked the resident's previous hall when she transferred. He said he the checked in the medication was a narcotic. He said he told halled the pharmacy for them, and
her shift on 10/04/22, not calling in for her shift and then not coming in on 10/07/22 and refusing to submit a drug test over that weekend. She said she was working the night of 10/08/22 and gave Resident #1 her pain pill at 6:19 p.m.		counted with the off-going nurse (si was correct for all medications that who the aide was) went into Reside and it still did not help. She said the some for her. She said she looked That was when she realized there is physician, to which he said he had supervisor. She said the RN supersthe hydrocodone. She notified the pappear to still be in the building. The medicine was nowhere to be found not show up, so she gave report ar nurse about the count being correct.	the did not remember the name of the rewere in the lockbox. She said she and ent #1's room because she was screame resident did not ask for pain medicine in her chart, saw she was on hydrocodwere no hydrocodone pills, or the narco just ordered some for her recently. She visor looked all over the building and in ohysician that the RN supervisor had ne physician refilled the prescription who is said when she got ready to leave ad counted with the nurse that filled interest and medications currently on the care	urse), and she ensured the count the CNA (she did not remember ning. She said they repositioned her, but she was still going to provide one pills, and went to pull one. Stic count sheet, so she called the esaid she then told the weekend all the other carts and did not find of found the medicine and it did not en she notified him that the est, the on-coming nurse (LVN M) did She said she explained to that rt, but the hydrocodone was
		her shift on 10/04/22, not calling in a drug test over that weekend. She pain pill at 6:19 p.m.	for her shift and then not coming in on	10/07/22 and refusing to submit to

			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, Z 623 Hwy 155n Gilmer, TX 75644	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Record review of the facility's Identifying Exploitation, Theft and Misappropriation of Resident Property policy with a date of April 2021 indicated, .4. Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 5. Examples of misappropriation of resident property include: . f. drug diversion (taking the resident's medication) .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. Building	(X3) DATE SURVEY COMPLETED	
	675602	B. Wing	11/09/2022	
NAME OF PROVIDER OR SUPPLII	NAME OF PROVIDER OR SUPPLIER		P CODE	
Focused Care of Gilmer		623 Hwy 155n Gilmer, TX 75644		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0684	Provide appropriate treatment and	care according to orders, resident's pre	eferences and goals.	
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 41656	
safety  Residents Affected - Few		ew, the facility failed to ensure treatme d in accordance with standards of prac		
	The facility failed to ensure Resident #1's surgical incision to her lower back was monitored or received wound care. The surgical incision was found to be reopened, infected and draining on [DATE]. Two pressu wounds to her left foot, identified upon admission on [DATE], also never were monitored, or received treatment.			
	2. The resident was sent to the hospital on [DATE] when her surgical wound was found by staff and appeared to be infected. She returned to the facility on [DATE], under the care of hospice, with antibiotic orders which were not started until [DATE]. She left with her family AMA on [DATE] and expired at home on [DATE].			
	These failures could place resident needs, serious impairment, and de	s at risk for not receiving necessary ca ath.	re and services to meet their	
	An Immediate Jeopardy (IJ) situation was identified on [DATE] at 12:50 p.m. While the IJ was removed on [DATE] at 2:50 p.m., the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems.			
	This failure resulted in the resident	not receiving urgent medical care and	resulted in death.	
	Findings included:			
	Record review of Resident #1's face sheet, with a print date of [DATE], indicated she was [AGE] years of admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. She had diagnoses including osteomyelitis of the lumbar (lower back) vertebra, diabetes, bipolar (a condition causing extreme mood swings from emotional highs to emotional lows), anxiety, high blood pressure, and acute (short term) kild failure.  Record review of Resident #1's hospital history and physical, with an admitted [DATE], indicated she had lumbar surgery in [DATE], but did not give the exact date. Her wound became infected, and she was readmitted to the hospital in [DATE] for removal of hardware in her spine. Blood cultures were positive for MRSA (a bacteria that is resistant to most antibiotics and causes hard to treat infections) and she was proposition on antibiotics. After a few more re-hospitalization s, she was diagnosed with osteomyelitis and underwer another surgery to stabilize her spine. An active drug list sent to the facility from the hospital on [DATE], indicated she was on doxycycline monohydrate 100mg and was to receive it long term. The orders did not indicate she was to follow up with any physician and did not address wound care or monitoring of wound			
	Record review of Resident #1's bas had no wounds or skin alterations.	seline care plan, completed on [DATE]	by the interim-DON indicated she	
	(continued on next page)			

			NO. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022	
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For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Record review of Resident #1's admission MDS, dated [DATE], indicated she had adequate hearing and vision, could understand and was understood by others, and had intact cognition. She exhibited behavioral symptoms not directed at others from 1 to 3 days of the look back period and she disrupted the living environment of others. She was totally dependent on two staff members with bed mobility, transfers, walking, dressing and toileting. She utilized a wheelchair for mobility. She was documented as not having surgery 100 days prior to admission, being at risk for pressure sores, but not having any pressure sores or surgical wounds.			
	Record review of Resident #1's care plan, with an admitted [DATE], indicated she had a history of falls due to her cognition, had impaired cognitive function, and had current skin conditions. The skin conditions were marked as surgical incision, surgical wound and open lesions other than stasis/venous areas. Interventions included treating per physician orders, monitor areas for increased breakdown or infection, monitor for and treat pain per physician orders, and assess skin weekly and record findings in the clinical record.			
	Record review of Resident #1's order summary report, indicated active orders as of [DATE] included orders for three areas to her lumbar spine to be cleansed with normal saline, dried, treated with collagen and honey, and dressed once a day. Orders for the areas were entered on [DATE] and no wound care orders were noted between her admission on [DATE] and her discharged on [DATE]. The resident was to receive a lumbar x-ray that was ordered on [DATE], with an end date of [DATE].			
	she had a surgical incision to her u	mission assessment, dated [DATE] and pper-mid vertebrae, a pressure wound assessment did not indicate the size or	to the outer side of her left foot and	
	Record review of Resident #1's weekly skin assessment, dated [DATE] and completed by LVN A, indicated she had a post-surgical site to her mid lumbar with 2 sutures noted, and a small area to the mid-site. The wound was covered with a dressing and tape. The two wounds to her left foot were covered with a foam dressing. The assessment did not indicate the size or condition of the wounds.			
		ctronic chart throughout the duration or y skin assessments during her stay in t		
	Record review of a nurse's note, written by LVN A and dated [DATE] at 12:45 p.m. indicated Resident #1 was just admitted to the facility from the hospital. LVN A completed a head-to-toe assessment on the resident and wrote see assessments. The resident was described as alert and oriented, in no pain, and he medications were on order. The note did not indicate the resident having a surgical incision to her back or pressure wounds to her left foot.			
	Record review of the 24-hour report dated [DATE] indicated Resident #1 admitted to the facility with a diagnosis of osteomyelitis, diabetes, high blood pressure, low thyroid, a foley catheter, and weakness. The report did not indicate her surgical incision or the wounds to her feet.			
	Record review of the 24-hour report The night shift indicated she had on	rt dated [DATE] indicated Resident #1 y steomyelitis of the vertebra.	velled out all shift on the day shift.	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022	
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	Lact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	EFICIENCIES d by full regulatory or LSC identifying information)		
F 0684  Level of Harm - Immediate jeopardy to resident health or safety	Record review of the 24-hour report dated [DATE] revealed no report found.  Record review of the 24-hour report dated [DATE], during Resident #1's COVID isolation, indicated she changed rooms to 314.  Record review of Resident #1's weekly skin assessment, dated [DATE] and completed by agency LVN B, indicated she had no surgical wounds, pressure wounds, or skin alterations.  Record review of a nurse's note, written by agency LVN C and dated [DATE] at 1:10 p.m., indicated Resid #1 was yelling out, had increased agitation/anxiety, was throwing things, and reporting pain to her lower back. The physician gave an order to x-ray her lumbar spine related to severe pain.  Record review of the 24-hour report dated [DATE], during Resident #1's COVID isolation, indicated she we to receive an x-ray to the lumbar spine on the day shift. She continued to yell out constantly on the night shift. The report did not contain any information regarding the resident's wounds to her feet or back.			
Residents Affected - Few				
	wounds to her feet or back.  Record review of the 24-hour report reports except for [DATE], [DATE].  Record review of a nurse's note, w	the 24-hour report book on [DATE] at 4:00 p.m., revealed no other COVID wing 24-hour [DATE], [DATE] and [DATE].  a nurse's note, written by agency LVN D and dated [DATE] at 3:26 a.m., indicated Resider to yell out, banging on the walls, and yelling for staff to help her. LVN D indicated the		
Record review of Resident #1's physician consult note, with an admitted [DATE], indicated sh hospice and was to continue doxycycline hyclate 100mg twice a day upon discharge and was hospice services. The ID Physician who had previously treated Resident #1 indicated in her pon [DATE], that the resident had discharged from the hospital on antibiotics with instructions them indefinitely due to recurrent back infections. The physician also indicated the resident had antibiotics while residing in the facility. The paperwork did not indicate the condition of the resonly wound care orders, and the resident's family wanted her to begin hospice care.				
	was readmitted to the facility on ho	ritten by LVN A and dated [DATE] at 12 spice services. She was described as l ar vertebrae, and two open areas to he	naving discoloration to her heels,	

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0684  Level of Harm - Immediate jeopardy to resident health or safety	Record review of Resident #1's readmission assessment, dated [DATE] and completed by LVN A, indicated she had a surgical incision to her upper-mid vertebrae, a pressure wound to her sacrum (the base of the spine, helping to form the pelvis), and vascular wounds to her left and right heels. The assessment did not indicate the size or condition of the wounds.		
Residents Affected - Few	Record review of Resident #1's discharge MDS, dated [DATE], indicated she had short-term memory problems, moderately impaired decision-making skills, and continued to exhibit behaviors not directed at others. She was totally dependent on staff for all ADLs, except for eating, which required only supervision. Further review indicated the resident as not having skin concerns or wounds.		
	was sent to the COVID unit. She sa	:10 p.m. LVN A said Resident #1 admi aid she did not know if anything was do dication administration. The nurses sai ents on their halls.	ne for the resident, such as skin
	During a phone interview on [DATE] at 3:14 p.m. Resident #1's family member said she did not know if the resident was given antibiotics at the facility, but had assumed she was not given them, since her infection never got better. She said she took Resident #1 out of the facility and took her home on hospice care. She said Resident #1 died at home on [DATE].		
	She denied observing any wounds touched and she would not turn all [DATE], the resident had been comresident a laxative and later, the rechanged. The aide went to change amount. She said she believed the movement. She said she initially the way over and saw the wound. The She said when she pulled the reside amounts of drainage came out with a yellowish-green tint, like a snot cand looked in the chart to see if an said LVN B sent the resident out be hospital, she was cognitive and kneed to the said the said that the said that the said that the said LVN B sent the resident out be hospital, she was cognitive and kneed the said that the said	:52 p.m. CNA E said she had worked won her back because on the COVID had the way over. She said the night she for plaining of pain from not having a bown sident told the aide she had gone to the her, and saw the sheets were soiled a resident felt the wetness from her wou ought it was a bowel movement as well wound was purple and covered by the lent's skin taught, she could physically a even minor touch. She said the drains olor, and it smelled. She said agency L by wound care had been ordered for the exause of the state of the wound. She saw the aide's name and was with it, but ely intact and would just holler out for her	all the resident would scream when bund the wound on her back, el movement. The nurse gave the el bathroom and needed to be and it was a very substantial and and thought it was a bowel I, until she rolled the resident all the flaps of skin due to her obesity, see into the wound and large age was chunky and gritty and was VN B was unaware of the wound wound but did not find any. She said before the resident went to the after the hospital she did not know
	During an interview on [DATE] at 4:18 p.m. CNA G said she did not remember Resident #1 having any wounds to her back or any wounds at all. She said she was never aware the resident had a surgical incision over her spine and had never been told of any wounds. She said she was not very familiar with the resident and only worked with her maybe 4 or 5 times during the resident's stay.		
	(continued on next page)		

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	between days and nights. She said Resident #1 was obese and flabby up the fold and pull her skin taught wound was pretty long because it waybe a quarter of her spine. She She said she went back to look at to the facility. She said the drainag She said she did not remember the documented the resident had no w remembered the last time she took pills, which would be doxycycline. Suring a phone interview on [DATE follow up with her, but that never have due to hospital error, facility er looked or smelled like at the hospit During an interview on [DATE] at 2 and paperwork. She said she was incision over her spine. When the r nurse did not take off the bandage the hospital. She did a thorough he spine and two wounds to her feet. Forders they had in place at the hos when she saw the wounds to the rebut she gave all the paperwork to toncoming shift could take care of the During an interview on [DATE] at 2 care orders for Resident #1 and did changes for her on the COVID wing over.  During a phone interview on [DATE] at 2 care orders and the coview on the coview of the coview on the covi	:20 p.m. LVN A said she did part of Re told in report from the discharging hosp esident arrived at the facility, she had a because she was told wound care had ead to toe skin assessment and noted to the said the hospital did not say anyth pital or anything about the resident following about the resident following about the resident following he ADON. The ADON said she would place rest.  :55 p.m. agency LVN D said she did not not remember seeing any wounds whigh the said the resident was bad at turn.  E] at 4:00 p.m. agency LVN H said she covided the covided wing.	If the wound care. She said the wound. She said she had to pick and swinging at staff. She said the know how long for sure. She said the know how long for sure. She said the known drainage poured out of it. IRSA in her spine before she came did not appear to be red or swollen. The said she tent on [DATE], but if she tent over completely. She said she tig the resident brown and yellow tent left with her family on [DATE]. The had wanted the resident to the up never happened, whether it tould not recall what the wound  The sident #1's admission assessment total that the resident had a surgical at dressing over the incision. The Indeed before the resident left the resident had the wound to her ting about what kind of wound care towing up with a physician. She said the put the orders in for wound care, tout all the orders in, and the  The tremember seeing any wound then she would do incontinent thing and could not turn all the way  The did not ever remember doing  The would not say for sure if Resident #1  The did not ever remember doing  The would not say for sure if Resident #1  The did not say for sure if Resident #1  The bered the resident yelling out and

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	aware of Resident #1 having any wishe helped LVN A put the orders in with a physician, she did not put are one followed up on getting her wound find the resident's x-ray of her burning a phone interview on [DATE resident not receiving wound care to her back and had not been aware to her back and had not been aware he would have made sure staff well her into the ID for follow up. He sait the facility had never made a follow.  During a phone interview on [DATE had wounds anywhere on her body she did not know if the resident had the resident's lumbar spine on [DATE had wounds anywhere on her body she did not know if the resident had the resident's lumbar spine on [DATE said she worked the 6a to 2p shift when she came back that right, she company to see where the results said the system had been out and the x-ray technician. She said the tomorning of [DATE] that the x-ray technician. She said the tworning a phone interview on [DATE Resident #1's back pain. She said did not remember the resident having a surgical Record review of the facility's Char promptly notify the resident, his or resident's medical/mental condition.  Policy Interpretation and Implement 1. The nurse will notify the resident.	E] at 10:19 a.m. agency LVN C said shew. She said the resident would not let the dany wounds to her back. She said the TE] since she was complaining of pain hen would not let them reposition her con [DATE] and then had to come back to said when she called the x-ray result was not rewere. She said when she called the x-ray he was not able to see anything on his echnician never came on her shift and achnician had not come and to call and the resident was always yelling out due ing any wounds to her feet or her back. The analysis of the Attending Physician, and represent and/or status (e.g., changes in level of the physical/emotional/mental conditional treatment significantly;	d a wound to her spine. She said for wound care or for following up said they were both unaware no in. The interim-DON said she could rer obtained.  In said he was not aware of the mot received the results of the x-ray had he known all this information, tained the spinal x-ray, and gotten riscian's name) and was not aware and did not remember if Resident #1 from turn her all the way over, so a physician did order an x-ray for to her there. She said the resident or turn her all the way over. She to work a 10p to 6 a shift. She said exceived so she called the x-ray and ycompany, the on-call operator end but would send a message to she notified the 6a to 2p nurse, the follow up with the x-ray company.  In notified about an x-ray for to her psychological issues. She she denied anyone ever notifying policy indicated, Our facility shall tative (sponsor) of changes in the force resident rights, etc.).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	identification number: 675602	A. Building B. Wing	11/09/2022	
NAME OF PROVIDER OR SUPPLIE	L ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Focused Care of Gilmer		623 Hwy 155n Gilmer, TX 75644		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	T OF DEFICIENCIES preceded by full regulatory or LSC identifying information)		
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	An Immediate Jeopardy (IJ) was id Administrator and DON were notified During an interview on [DATE] at 1 and ADON both indicated they had reflecting her wounds. The interimshe did not know the resident had a documented, and she didn't see an resident's change in doxycycline with the resident's doxycycline had beer [DATE].  The following Plan of Removal subthe following:  [DATE]  Neglect  Plan of Action  Resident in question (Resident #1) building. A chart review of her phar of Clinical Operations to review whreview orders and failed to confirm  Audit of all medications compared ensure that no other residents have Director of Clinical Operations, Assand Treatment Nurse reviewed clin of family and physician.  Director of Clinical Operations, Assover the last six months to ensure the Interview of Clinical Operations over the last six months to ensure the Interview of Worsening infective and symptoms of worsening infective at the Interview of Worsening infective and Symptoms of worsening infective at the Interview of Worsening infective and Symptoms of worsening infective at the Interview of Interview of Worsening infective and Symptoms of Worsening infective at the Interview of Interview of Worsening infective and Symptoms of Worsening infective at the Interview of Interview	entified on [DATE] at 12:50 p.m., due to ad of the IJ and the IJ template was proceed of the IJ and the IJ template was proceed on the IJ and the IJ template was proceed on the IJ and the IJ template was proceed on the IJ and the IJ skin and the resident any skin issues. She said she could only documentation about wounds. The interest of the IJ and the IJ and IJ a	o the above failures. The ovided on [DATE] at 1:09 p.m. and Administrator, the interim-DON assessment on [DATE] not thad no skin alterations because by go by what the LVN A had neterim-DON said she accepted the ing approval. She did not realize was not approved by her until did not approved by her until did not approved by her until did not realize was not approved by her until did not realize was not approved by her until did not realize was not approved by her until did not realize was not approved by her until did not realize was not approved by her until did not realize was completed by the Director of Nurses in training was to did not realize was completed on [DATE] to did not realize was not approved by her until did not realize was not approved by her unti	
	which includes:  1. Physician must be notified of any new orders that were not written by the physician within 2 hours of admission or re-admission via phone.			
	Physician must be notified of any doses as per policy. See attached.	2. Physician must be notified of any missed dosages of medication as prescribed no later than 3 missed doses as per policy. See attached.		
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022	
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	within 2 hours of admission or re-added 4. Physician to be notified of any characteristics withing 2 hours of the Director of Clinical Operations,	y change in medical conditions including worsening infections, falls, or is of assessment. See Monitoring form for changes in condition attached.  Ons, Assistant Director of Clinical Operations, Treatment Nurse, and licensed in on following physician's orders as it pertains to x-ray services on [DATE] by		
	<ol> <li>Nurses must complete orders as written.</li> <li>If an order is not or cannot be complete physician must be notified via phone within 2 hours of receiving notification.</li> <li>Each shift must follow up on x-ray orders until results are obtained.</li> </ol>			
	Newly hired nurses will receive in-services on proper physician notification processes.			
	Validation/Monitoring Tools			
	Director of Clinical Operations or designee will validate staff knowledge base through random questioning.			
		esignee will review records for any new hysician notification and appropriate fo		
	Director of Clinical Operations or do x-rays are obtained and physician r	esignee will review all x-ray order daily notification is completed.	in the clinical meeting to ensure	
		completed by admitting nurse to ensure nitiated within 2 hours of admission. See		
	Change in conditions check list to be and physician notification. Beginning	pe utilized to ensure nurse competency ng [DATE].	with completion of assessments	
	On [DATE] from 11:40 a.m. to 2:50 sufficiently to remove the IJ by:	p.m. the surveyor confirmed the facility	y implemented their plan of removal	
	During interviews with the RN weekend supervisor, the ADON, LVN L and LVN N between 11:45 a.m. an 2:15 p.m., staff indicated they had received adequate training regarding skin assessments, antibiotics, antibiotic orders and use of 24 hour reports.			
		us Report dated [DATE] at 3:18 PM, by s being reviewed by the DON for narcot		
	(continued on next page)			

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	During an interview on [DATE] at 1 residents to ensure there were no reach resident had orders and medifor pain. The interim-DON said all rwithin 2 hours. She said all nursing been trained on monitoring antibiot said nurses were to notify the DON Preventionist for the facility at the time wound care nurse will take over the Record review of PCP records between the system. Paper new orders on the report.  The Administrator and DON were in The facility remained out of compliant.	and 1:15 p.m. of staff who had received stated their understanding of the education 2:47 p.m., the interim-DON said she conew skin issues. She said she also revication available. The interim-DON said residents were to have a skin assessment of the schedule and staff had been trained on skin assessics for the duration of the schedule and any time antibiotics are ordered. She time, until the new wound care nurse coat responsibility.  Ween 12:47 p.m. and 1:15 p.m. showed a representation of the lamediate Jeopardy was ance at a severity level of actual harm to ty's need to evaluate the effectiveness.	cation provided.  Inducted a full sweep of all 37 ewed all medications to ensure I she also assessed each resident ent on admission or re-admission ments. She said nurses had also I 3 days after for any reactions. She said she is the Infection Control impletes her training, then the new I orders were showing on the and the nurses had documented removed on [DATE], at 2:50 p.m. that is not immediate jeopardy and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
		B. Willy	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Focused Care of Gilmer		623 Hwy 155n Gilmer, TX 75644	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0755	Provide pharmaceutical services to licensed pharmacist.	meet the needs of each resident and	employ or obtain the services of a
Level of Harm - Immediate jeopardy to resident health or safety		IAVE BEEN EDITED TO PROTECT CO	
Residents Affected - Few		ew, the facility failed to provide pharma administering of all drugs to meet the n egimen. (Resident #1)	
	The facility failed to ensure Reside and 10/18/22 and again between 1	nt #1 was given her indefinitely prescrit 0/21/22 and 10/26/22.	oed doxycycline between 09/27/22
	This failure placed residents at risk	for medical complications, decreased	quality of life, or even death.
	An Immediate Jeopardy (IJ) situation was identified on 11/04/22 at 12:50 p.m. While the IJ was removed on 11/06/22 at 2:50 p.m., the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems.		
	Findings included:		
	I .	e sheet, with a print date of 11/07/22, i [DATE] and discharged on [DATE]. Shoack) vertebra.	
	Record review of Resident #1's hospital history and physical, with an admitted [DATE], indicated she had lumbar surgery in May 2022, but did not give the exact date. Her wound became infected, and she was readmitted to the hospital in July 2022 for removal of hardware in her spine. Blood cultures were positive for MRSA (a bacteria that is resistant to most antibiotics and causes hard to treat infections) and she was placed on antibiotics. After a few more re-hospitalization s, she was diagnosed with osteomyelitis and underwent another surgery to stabilize her spine. An active drug list sent to the facility from the hospital on 09/23/22, indicated she was on doxycycline monohydrate 100mg and was to receive it long term. The orders did not indicate she was to follow up with any physician and did not address wound care or monitoring of wounds.		
	Record review of Resident #1's admission MDS, dated [DATE], indicated she had adequate hearing and vision, could understand and was understood by others, and had intact cognition. She exhibited behavioral symptoms not directed at others from 1 to 3 days of the look back period and she disrupted the living environment of others. She was totally dependent on two staff members with bed mobility, transfers, walking dressing and toileting. She utilized a wheelchair for mobility. She was documented as not having surgery 10 days prior to admission, being at risk for pressure sores, but not having any pressure sores or surgical wounds. The MDS also did not indicate she had received antibiotics within the first 7 days of her stay.		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022	
NAME OF PROVIDER OR SUPPLIER  Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZI 623 Hwy 155n Gilmer, TX 75644	P CODE	
For information on the nursing home's p	plan to correct this deficiency, please con	tact 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 0755  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Record review of Resident #1's care plan, with an admitted [DATE], indicated she had a history of falls due to her cognition, had impaired cognitive function, and had current skin conditions. The skin conditions were marked as surgical incision, surgical wound and open lesions other than stasis/venous areas. Interventions included treating per physician orders, monitor areas for increased breakdown or infection, monitor for and treat pain per physician orders, and assess skin weekly and record findings in the clinical record.  Record review of Resident #1's order for doxycycline 100mg capsule by mouth twice a day (an antibiotic) was entered on 10/21/22 and had a start date of 10/26/22.  Record review of Resident #1's order summary report, indicated discontinued orders as of 10/01/22 through			
	<ul> <li>10/28/22 included the following orders:</li> <li>*doxycycline monohydrate 100mg capsules twice a day and give long term, ordered on 9/27/22 and an end date of 10/03/22.</li> <li>*doxycycline hyclate 100mg tablet twice a day was ordered on 10/21/22 and ended on 10/21/22.</li> <li>*doxycycline monohydrate 100mg capsules twice a day was ordered on 10/21/22 with a start date of</li> </ul>			
	10/26/22.  *an x-ray to her lumbar spine for se	evere pain was ordered on 10/08/22 an	d ended on 10/11/22.	
	Record review of Resident #1's Sethrough 09/01/22 to 09/30/22.	ptember MAR, indicated she did not re-	ceive doxycycline monohydrate	
	Record review of Resident #1's October MAR, indicated she began receiving doxycycline monohydrate 100mg capsules on 10/26/22 at 9 p.m.			
	Record review on 11/03/22 at 3:00 #1's doxycycline being destroyed w	p.m. of the facility drug destruction log vithin the past month.	revealed no record of Resident	
		t dated 09/27/22 indicated Resident #1 s, high blood pressure, low thyroid, a fo incision or the wounds to her feet.		
	Record review of the 24-hour repor The night shift indicated she had on	t dated 09/29/22 indicated Resident #1 steomyelitis of the vertebra.	yelled out all shift on the day shift.	
	Record review of the 24-hour repor	t dated 09/30/22 revealed no report for	und.	
	Record review of a nurse's note, written by agency LVN C and dated 10/08/22 at 1:10 p.m., indicated Resident #1 was yelling out, had increased agitation/anxiety, was throwing things, and reporting pain to her lower back. The physician gave an order to x-ray her lumbar spine related to severe pain.			
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022	
NAME OF PROVIDER OR SUPPLII Focused Care of Gilmer	NAME OF PROVIDER OR SUPPLIER  Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n	
		Gilmer, TX 75644		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0755  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Record review of Resident #1's physician consult note, with an admitted [DATE], indicated she admitted for hospice and was to continue doxycycline hyclate 100mg twice a day upon discharge and was to be on hospice services. The ID Physician who had previously treated Resident #1 indicated in her progress notes on 10/20/22, that the resident had discharged from the hospital on antibiotics with instructions to continue them indefinitely due to recurrent back infections. The physician also indicated the resident had gone off the antibiotics while residing in the facility. The paperwork did not indicate the condition of the resident's wounds, only wound care orders, and the resident's family wanted her to begin hospice care.			
	Record review of Resident #1's discharge MDS, dated [DATE], indicated she had short-term memory problems, moderately impaired decision-making skills, and continued to exhibit behaviors not directed at others. She was totally dependent on staff for all ADLs, except for eating, which required only supervision. She was again documented as not having skin concerns or wounds, and as not receiving an antibiotic in the past 7 days.  During an interview on 11/01/22 at 2:10 p.m. with RN F and LVN A, RN F said she had issues earlier in the day, on 11/01/22, while putting in orders for doxycycline hyclate for a different resident. She said the pharmacy automatically kicked out the order and wanted to switch it to doxycycline monohydrate instead. She said she had been looking for the order and realized it was no longer there, then she realized the pharmacy had sent the new order for her to confirm. She said because LVN A was an LVN, she could not confirm orders, only RNs could. She said LVN A would have put in the doxycycline order and then when an order change confirmation came in, the DON would have to approve it since she was an RN. LVN A said Resident #1 admitted and very quickly into her stay was sent to the COVID unit. She said she did not know if anything was done for the resident, such as skin assessments, wound care, and medication administration. The nurses said they did not have a wound care nurse and had do their own treatments on their halls.			
	hall. She said the night she found to pain from not having a bowel move was a very substantial amount. She thought it was a bowel movement. rolled the resident all the way over skin due to her obesity. She said wound and large amounts of drains and gritty and was a yellowish-gree	3:52 p.m. CNA E said she had worked he wound on her back, 10/18/22, the rement. The aide went to change her, are said she believed the resident felt the She said she initially thought it was a band saw the wound. The wound was prhen she pulled the resident's skin taugage came out with even minor touch. Sen tint, like a snot color, and it smelled in the chart to see if any wound care has	esident had been complaining of a saw the sheets were soiled and it wetness from her wound and sowel movement as well, until she urple and covered by the flaps of ht, she could physically see into the he said the drainage was chunky She said agency LVN B was	
	back, dark brown drainage poured resident's chart and saw she had N did not have an odor and the woun time she took care of the resident,	/22 a 4:30 p.m. agency LVN B said who out of the wound over her spine. She sate of the wound over her spine. She sate of the work of the w	aid she went back to look at the the facility. She said the drainage She said she remembered the last and yellow pills, which would be	

			No. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022	
NAME OF PROVIDER OR SUPPLIE Focused Care of Gilmer	NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n Gilmer, TX 75644	
For information on the nursing home's	nlan to correct this deficiency please con-	tact the nursing home or the state survey	agency	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	<u> </u>		
F 0755  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	During a phone interview on 11/02/ therapeutic interchanges to be made the doctor ordered doxycycline more out the order for hyclate and enter at the corporate office was usually the the corporation did it then most like reasons for the therapeutic interchat followed. She said she saw in the sechanged it to doxycycline monohyd them came in on 10/21/22, they did  During a phone interview on 11/02/ Resident #1, at the hospital, that shan order for the resident to have intervite orders there, she was not sure  During an interview on 11/03/22 at assessment and paperwork. She sa would have followed up on it for 72 administer it.  During a phone interview on 11/03/ being on an antibiotic while she wo  During a phone interview on 11/03/ was on an antibiotic. She said she just room, she would say she had not b  During an interview on 11/03/22 at aware of Resident #1 having any w she helped LVN A put the orders in with a physician, she did not put an pharmacy kept kicking out the doxy out automatically and then resubmi antibiotics until 10/26/22. The interi appeared the x-ray was never obta	22 at 9:00 a.m. the Pharmacist said the de whenever an order was put in for a way a new order for the monohydrate, whice one that requested the therapeutic integrated in the design of the monohydrate, whice one that requested the therapeutic integrated in the facilities under that corporation divide anges, such as cost to the facility, or encystem where the doxycycline was ordered capsules. She said they sent out of the facility is not send any out because the refill was read and not been receiving antibiotics at definite doxycycline at the facility, but see if the resident received the antibiotics at definite doxycycline at the facility, but see if the resident received the antibiotics at definite doxycycline at the facility, but see if the resident received the antibiotics at definite doxycycline at the facility, but see if the resident received the antibiotics at definite doxycycline at the facility, but see if the resident received the antibiotics at definite doxycycline at the facility, but see if the resident received the antibiotics at definite doxycycline at the facility, but see if the resident received the antibiotics at definite doxycycline at the facility and she was at 4:00 p.m. agency LVN H said she at remembered the resident yelling out a seen yelling and did not need anyone to the feet but did know she had and since she did not see any orders and the LVNs could not ted. They both denied knowing about m-DON said she could not find the resident yelling the resident pounds to her feet but down and since she did not find the resident pounds to her feet but did knowing about m-DON said she could not find the resident pounds to her feet but down and since she did not find the resident pounds to her feet but did knowing about m-DON said she could not find the resident pounds to her feet but did knowing about m-DON said she could not find the resident pounds to her feet but did knowing about m-DON said she could not find the resident pounds to her feet but did knowing about m-DON said she could not find	e medical director had signed for wrong medication. For example, if e hyclate, the system would kick han RN must approve. She said terchanges and if one facility under d. She said there were different issuring the correct order was ered on 09/27/22 and the system 50 pills that day. The next order for as too soon from the last fill date.  she was told by the family and the facility. She said she did give ince she did not go to the facility, or so root.  Resident #1's admission he resident's doxycycline, she ing up on it, then she did not  did not remember the resident  did not remember if the resident  and when they would go in her or come in there.  DON, the ADON said she was not drawound to her spine. She said for wound care or for following up said they were unaware the see the orders were being kicked the resident not receiving her ident's x-ray of her back and it	

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	070002	B. Wing		
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Focused Care of Gilmer		623 Hwy 155n Gilmer, TX 75644		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0755  Level of Harm - Immediate jeopardy to resident health or safety	During a phone interview on 11/08/22 at 3:28 p.m. LVN L denied ever being notified about an x-ray for Resident #1's back pain. She said the resident was always yelling out due to her psychological issues. She did not remember the resident having any wounds to her feet or her back. She denied anyone ever notifying her of the resident having a surgical wound to her back.			
Residents Affected - Few	Record review of the facility's General Guidelines for Medication Administration policy indicated, .6. If a dose of regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time (e.g., the resident is not in the facility at a scheduled time or a started dose of an antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses, or in accordance with facility policy, of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response.  An Immediate Jeopardy (IJ) was identified on 11/04/22 at 12:50 p.m., due to the above failures. The Administrator and DON were notified of the IJ and the IJ template was provided on 11/04/22 at 1:09 p.m.  During an interview on 11/04/22 at 1:09 p.m. with the interim-DON, ADON and Administrator, the interim-DON said she accepted the resident's change in doxycycline when she saw it was in the system awaiting approval. She did not realize the resident's doxycycline had been pending approval since 10/21/22 and was not approved by her until 10/26/22. She said she approved orders as they popped up in the system, but she did not realize they were popping up due to therapeutic interchanges. She said the reason it took her until 10/26/22 to approve the doxycycline was because she left the building on 10/21/22 and did not return until 10/26/22.			
	The following Plan of Removal sub the following:	elan of Removal submitted by the facility was accepted on 11/06/22 at 8:52 a.m. and included		
	11-4-22			
	Neglect			
	Plan of Action			
	Resident in question (Resident #1) that did not receive her antibiotics as ordered and is no longer in the building. A chart review of her pharmacy orders and therapeutic interchange was completed by the Director of Clinical Operations to review what transpired. At the time a new Director of Nurses in training was to review orders and failed to confirm new antibiotic orders.			
		idit of all medications compared to current orders for all residents in house was completed on 11/05/22 to sure that no other residents have missed medications.		
		ical Operations, Assistant Director of Clinical Operations, Clinical Reimbursement Coordina Nurse reviewed clinical records for residents with wounds to ensure documented notificatio hysician.		
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675602	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2022
NAME OF PROVIDER OR SUPPLIER Focused Care of Gilmer		STREET ADDRESS, CITY, STATE, ZIP CODE 623 Hwy 155n	
For information on the nursing home's	plan to correct this deficiency, please con	Gilmer, TX 75644	agency
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Director of Clinical Operations, Ass over the last six months to ensure for the Director of Clinical Operations, Licensed Nurses will be provided in and symptoms of worsening infection which includes:  1. Physician must be notified of any admission or re-admission via phore  2. Physician must be notified of any doses as per policy. See attached.  3. Physician must be notified of any within 2 hours of admission or re-admission or clinical Operations or definition.  3. Each shift must complete orders as 2. If an order is not or cannot be conotification.  3. Each shift must follow up on x-ray Newly hired nurses will receive in-section of Clinical Operations or definition of Clini	istant Director of Clinical Operations, wollow thru and notification of findings.  Assistant Director of Clinical Operationservice education related to Notifications beginning on 11-4-22 by Director of the new orders that were not written by the new orders as prediction as prediction of the new orders and the new orders as it perturbed in the new orders as it perturbed in the new orders are it perturbed in the new orders as it perturbed in the new orders are in the new	will review all x-rays ordered with  Ins, Treatment Nurse and All on of Change, including any signs of Clinical Operations or designee  The physician within 2 hours of scribed no later than 3 missed  Insisted mission and or wound orders  Worsening infections, falls, or changes in condition attached.  The physician within 2 hours of receiving  The physician within 2 hours of receiving  The physician within 2 hours of receiving  The processes.  The physician within 2 hours of receiving  The processes.  The physician within 2 hours of receiving  The processes.  The physician within 2 hours of receiving  The processes.  The physician within 2 hours of receiving  The processes.  The physician within 2 hours of receiving  The processes.  The physician within 2 hours of receiving  The processes of the physician

Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few  During interviews with the RN weekend supervisor, the ADON, LVN L and LVN N between 11:45 a.m 2:15 p.m., staff indicated they had received adequate training regarding skin assessments, antibiotics antibiotic orders and use of 24 hour reports.  Record review of A Midnight Census Report dated 11/05/22 at 3:18 PM, by the interim-DON showed Residents had been checked off as being reviewed by the DON for narcotics and all medications.  Record review between 12:47 p.m. and 1:15 p.m. of staff who had received training, indicated 12 staff been educated over the phone and stated their understanding of the education provided.  During an interview on 11/02/22 at 12:47 p.m., the interim-DON said she conducted a full sweep of all residents to ensure there were no new skin issues. She said she also reviewed all medications to ensure there were no new skin issues. She said she also reviewed all medications to ensure there were no new skin issues. She said she also reviewed all medications to ensure there were no new skin issues. She said she also reviewed all medications to ensure there were no new skin issues. She said she also reviewed all medications to ensure there were no new skin issues. She said she also reviewed all medications to ensure there were no new skin issues. She said she also assessed each refor pain. The interim-DON said all residents were to have a skin assessments. She said nurses had been trained on monitoring antibiotics for the duration of the schedule and 3 days after for any reactic said nurses were to notify the DON any time antibiotics are ordered. She said she is the Infection Cor					
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Residents had been checked off as being reviewed by the DON for narcotics and all medications.  Record review between 12:47 p.m. and 1:15 p.m. of staff who had received training, indicated 12 staff been educated over the phone and stated their understanding of the education provided.  During an interview on 11/02/22 at 12:47 p.m., the interim-DON said she conducted a full sweep of al residents to ensure there were no new skin issues. She said she also reviewed all medications to ensure the resident had orders and medication available. The interim-DON said she also assessed each refor pain. The interim-DON said all residents were to have a skin assessment on admission or re-admit within 2 hours. She said all nursing staff had been trained on skin assessments. She said nurses had been trained on monitoring antibiotics for the duration of the schedule and 3 days after for any reaction said nurses were to notify the DON any time antibiotics are ordered. She said she is the Infection Corpreventionist for the facility at the time, until the new wound care nurse completes her training, then the wound care nurse will take over that responsibility.  Record review of PCP records between 12:47 p.m. and 1:15 p.m. showed orders were showing on the 24-hour report in the system. Paper 24-hour reports were also reviewed, and the nurses had docume new orders on the report.  The Administrator and DON were informed the Immediate Jeopardy was removed on 11/06/22, at 2:5 The facility remained out of compliance at a severity level of actual harm that is not immediate jeopard.	Residents Affected - Few	During interviews with the RN weekend supervisor, the ADON, LVN L and LVN N between 11:45 a.m. and 2:15 p.m., staff indicated they had received adequate training regarding skin assessments, antibiotics, antibiotic orders and use of 24 hour reports.			
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