STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675602	A. Building B. Wing	11/09/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656 Based on interview and record review the facility failed to immediately inform the physician when there was a significant change in the resident's physical and mental status for 1 of 6 residents whose records were reviewed for change in condition. (Resident #1) 1. The facility failed to notify the physician Resident #1 was not receiving her indefinitely prescribed antibiotic related to vertebral osteomyelitis. 2. The facility failed to notify the physician Resident #1 did not receive her vertebral x-ray that was ordered related to her complaints of severe back pain. 3. The facility failed to notify the physician Resident #1 had pressure wounds to her feet and a surgical wound over her lumbar spine, upon her admission to the facility. 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. These failures 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 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) kidney failure. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 baseline care plan, completed on 09/27/22 by the interim-DON indicated she had no wounds or skin alterations. 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. The MDS also did not indicate she had received antibiotics within the first 7 days of her stay. 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 11/07/22 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 10/27/22. An 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 10/28/22 included the following orders: *doxycycline monohydrate 100mg capsules twice a day and give long term, ordered on 9/27/22 and an end date of 10/03/22. *doxycycline hyclate 100mg tablet twice a day was ordered on 10/21/22 and ended on 10/21/22. *doxycycline monohydrate 100mg capsules twice a day was ordered on 10/21/22 with a start date of 10/26/22. *an x-ray to her lumbar spine for severe pain was ordered on 10/08/22 and ended on 10/11/22. (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 Resident #1's September MAR, indicated she did not receive doxycycline monohydrate through 09/01/22 to 09/30/22. 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 p.m. of the facility drug destruction log revealed no record of Resident #1's doxycycline being destroyed within the past month. Record review of Resident #1's admission assessment, dated 09/27/22 and completed by LVN A, indicated she had a surgical incision to her upper-mid vertebrae, a pressure wound to the outer side of her left foot and the inner side of her left foot. The assessment did not indicate the size or condition of the wounds. Record review of Resident #1's weekly skin assessment, dated 09/27/22 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. Record review of Resident #1's electronic chart throughout the duration of the investigation between 11/01/22 to 11/9/22 revealed no other weekly skin assessments during her stay in the facility. Record review of a nurse's note, written by LVN A and dated 09/27/22 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 her 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 09/27/22 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 dated 09/29/22 indicated Resident #1 yelled out all shift on the day shift. The night shift indicated she had osteomyelitis of the vertebra. Record review of a nurse's note, written by LVN A and dated 09/30/22 at 3:27 p.m., indicated Resident #1 had nausea and vomiting caused by coughing. A COVID test was conducted, and she was found to be positive. Isolation and contact precautions were to be initiated. Record review of the 24-hour report dated 09/30/22 revealed no report found. Record review of the 24-hour report dated 10/01/22, during Resident #1's COVID isolation, indicated she changed rooms to 314. Record review of Resident #1's weekly skin assessment, dated 10/04/22 and completed by agency LVN B, indicated she had no surgical wounds, pressure wounds, or skin alterations. (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 shift. Record review of the 24-hour report dated 10/09/22, during Resident #1's COVID isolation, indicated they were still awaiting the x-ray to her spine. Record review of the 24-hour report book on 11/03/22 at 4:00 p.m., revealed no other COVID wing 24-hour reports except for 10/01/22, 10/08/22 and 10/09/22. Record review of a nurse's note, written by agency LVN D and dated 10/10/22 at 3:26 a.m., indicated Resident #1 was continuing to yell out, banging on the walls, and yelling for staff to help her. LVN D indicated 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 10/21/22 at 12:00 p.m., indicated Resident #1 was readmitted to the facility on hospice services. She was described as having discoloration to her heels, the dehisced wound over her lumbar vertebrae, and two open areas to her buttocks. Record review of Resident #1's readmission assessment, dated 10/21/22 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. 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. (continued on next page)

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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 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. During an interview on 11/01/22 at 3:52 p.m. CNA E said she had worked with Resident #1 on the COVID hall. She denied observing any wounds on her back because on the COVID hall the resident would scream when touched and she would not turn all the way over. She said the night she found the wound on her back, 10/18/22, the resident had been complaining of pain from not having a bowel movement. The nurse gave the resident 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 felt the wetness from her wound and thought it was a bowel movement. She said she initially thought it was a bowel movement as well, until she rolled the resident all the way over and saw the wound. The wound was purple and covered by the flaps of skin due to her obesity. 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 minor touch. She said the drainage was chunky and gritty and was a yellowish-green tint, like a snot color, and it smelled. She said agency LVN B was unaware of the wound and looked in the chart to see if any wound care had been ordered for the wound but did not find any. She said LVN B sent the resident out because of the state of the wound. She said before the resident went to the hospital, she was cognitive and knew the aide's name and was with it, but after the hospital she did not know anyone and was no longer cognitively intact and would just holler out for help. During an interview on 11/01/22 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. 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. (continued on next page)

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F 0580 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 signed for therapeutic interchanges to be made whenever an order was put in for a wrong medication. For example, if the doctor ordered doxycycline monohydrate and staff entered doxycycline hyclate, the system would kick out the order for hyclate and enter a new order for the monohydrate, which an RN must approve. She said the corporate office was usually the one that requested the therapeutic interchanges and if one facility under the corporation did it then most likely all facilities under that corporation did. She said there were different 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 changed it to doxycycline monohydrate capsules. She said they sent out 60 pills that day. The next order for them came in on 10/21/22, they did not send any out because the refill was too soon from the last fill date. During a phone interview on 11/02/22 at 10:36 a.m. the ID physician said she was told by the family and Resident #1, at the hospital, that she had not been receiving antibiotics at the facility. She said she had wanted the resident to follow up with her, but that never happened. She was unsure why a follow up never happened, whether it was due to hospital error, facility error, or even family error. She said she could not recall what the wound looked or smelled like at the hospital when she arrived for treatment. She said she did give an order for the resident to have indefinite doxycycline at the facility, but since she did not go to the 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 resident had a surgical incision over her spine. When the resident arrived at the facility, she had a dressing over the incision. The nurse did not take off the bandage because she was told wound care had been done before the resident left the hospital. She did a thorough head to toe skin assessment and noted the resident had the wound to her spine and two wounds to her feet. She said the hospital did not say anything about what kind of wound care orders they had in place at the hospital or anything about the resident following up with a physician. She said when she saw the wounds to the resident's feet and back, she should have put the orders in for wound care, but she gave all the paperwork to the ADON. The ADON said she would put all the orders in, and the oncoming shift could take care of the rest. She said if she had given the initial dose of the resident's doxycycline, she would have followed up on it for 72 hours, so if there were no notes following up on it, then she did not administer it. During an interview on 11/03/22 at 2:55 p.m. agency LVN D said she did not remember seeing any wound care orders for Resident #1 and did not remember seeing any wounds when she would do incontinent changes for her on the COVID wing. She said the resident was bad at turning and could not turn all the way over. She said she did not remember if the resident was on an antibiotic or not. During a phone interview on 11/03/22 at 4:00 p.m. agency LVN H said she did not remember Resident #1 having wounds while she worked the COVID wing. She said she did not remember the resident being on an antibiotic while she worked the COVID wing. During a phone interview on 11/03/22 at 4:05 p.m. agency LVN J said she did not ever remember doing wound care on Resident #1 while she worked the COVID wing. She did not remember if the resident was on an antibiotic or not. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 11/03/22 4:10 p.m. agency LVN K said she could not say for sure if Resident #1 had wounds while she worked the COVID wing. She said she did not remember if the resident took an antibiotic. She said she just remembered the resident yelling out and when they would go in her room, she would say she had not been yelling and did not need anyone to come in there. During an interview on 11/03/22 at 4:25 p.m. with the ADON and interim-DON, the ADON said she was not aware of Resident #1 having any wounds to her feet but did know she had a wound to her spine. She said she helped LVN A put the orders in and since she did not see any orders for wound care or for following up with a physician, she did not put any in. The ADON and the interim-DON said they were both unaware no one followed up on getting her wound care or to follow up with a physician. They also were unaware the pharmacy kept kicking out the doxycycline orders and the LVNs could not see the orders were being kicked out automatically and then resubmitted. They both denied knowing about the resident not receiving her antibiotics until 10/26/22. The interim-DON said she could not find the resident's x-ray of her back and it appeared the x-ray was never obtained. During a phone interview on 11/04/22 at 10:30 a.m. Resident #1's Physician said he was not aware of the resident not receiving wound care to her feet or her back. He was also not aware of her not receiving her doxycycline. He said he had not received the results of the x-ray to her back and had not been aware the x-ray was not obtained. He said had he known all this information, he would have made sure staff were giving her the ordered antibiotics, obtained the spinal x-ray, and gotten her into the ID for follow up. He said he believed she was seen by (ID physician's name) and was not aware the facility had never made a follow up appointment. During a phone interview on 11/05/22 at 10:19 a.m. agency LVN C said she did not remember if Resident #1 had wounds anywhere on her body. She said the resident would not let them turn her all the way over, so she did not know if the resident had any wounds to her back. She said the physician did order an x-ray for the resident's lumbar spine on 10/08/22 since she was complaining of pain to her there. She said the resident said she had pain to her back but then would not let them reposition her or turn her all the way over. She said she worked the 6a to 2p shift on 10/08/22 and then had to come back to work a 10p to 6 a shift. She said when she came back that night, she saw where the x-ray result was not received so she called the x-ray company to see where the results were. She said when she called the x-ray company , the on-call operator said the system had been out and he was not able to see anything on his end but would send a message to the x-ray technician. She said the technician never came on her shift and she notified the 6a to 2p nurse, the morning of 10/09/22 that the x-ray technician had not come and to call and follow up with the x-ray company about getting it done that day. 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. Record review of the facility's Change in a Resident's Condition or Status policy indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care .resident rights, etc.) . Policy Interpretation and Implementation (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Audit of all medications compared to current orders for all residents in house was completed on 11/05/22 to ensure that no other residents have missed medications. Director of Clinical Operations, Assistant Director of Clinical Operations, Clinical Reimbursement Coordinator and Treatment Nurse reviewed clinical records for residents with wounds to ensure documented notification of family and physician. Director of Clinical Operations, Assistant Director of Clinical Operations, will review all x-rays ordered with over the last six months to ensure follow thru and notification of findings. The Director of Clinical Operations, Assistant Director of Clinical Operations, Treatment Nurse and All Licensed Nurses will be provided in-service education related to Notification of Change, including any signs and symptoms of worsening infections beginning on 11-4-22 by Director of Clinical Operations or designee 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. 2. Physician must be notified of any missed dosages of medication as prescribed no later than 3 missed doses as per policy. See attached. 3. Physician must be notified of any wounds present on admission or readmission and or wound orders within 2 hours of admission or re-admission via phone. 4. Physician to be notified of any change in medical conditions including worsening infections, falls, or medical changes withing 2 hours of assessment. See Monitoring form for changes in condition attached. The Director of Clinical Operations, Assistant Director of Clinical Operations, Treatment Nurse, and licensed nurses to be provided education on following physician's orders as it pertains to x-ray services on 11-4-22 by Director of Clinical Operations or designee which includes: 1. Nurses must complete orders as written. 2. If an order is not or cannot be complete physician must be notified via phone within 2 hours of receiving notification. 3. Each shift must follow up on x-ray orders until results are obtained. 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. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Clinical Operations or designee will review records for any newly admitted or readmitted resident daily in clinical meeting to ensure physician notification and appropriate follow up. Beginning 11-7-22. Director of Clinical Operations or designee will review all x-ray order daily in the clinical meeting to ensure x-rays are obtained and physician notification is completed. Admission check list form is to be completed by admitting nurse to ensure appropriate notification and completion of assessments to be initiated within 2 hours of admission. See form attached. Change in conditions check list to be utilized to ensure nurse competency with completion of assessments and physician notification. Beginning 11-7-22. On 11/06/22 from 11:40 a.m. to 2:50 p.m. the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: 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. Record review of A Midnight Census Report dated 11/05/22 at 3:18 PM, by the interim-DON showed 37 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 had 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 37 residents to ensure there were no new skin issues. She said she also reviewed all medications to ensure each resident had orders and medication available. The interim-DON said she also assessed each resident for pain. The interim-DON said all residents were to have a skin assessment on admission or re-admission within 2 hours. She said all nursing staff had been trained on skin assessments. She said nurses had also been trained on monitoring antibiotics for the duration of the schedule and 3 days after for any reactions. She said nurses were to notify the DON any time antibiotics are ordered. She said she is the Infection Control Preventionist for the facility at the time, until the new wound care nurse completes her training, then the new 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 documented new orders on the report. The Administrator and DON were informed the Immediate Jeopardy was removed on 11/06/22, at 2:50 p.m. The facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.

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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 dignity. 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) kidney 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, walking, dressing and toileting. She utilized a wheelchair for mobility. She was documented as receiving an opioid for the entire 7 day look back period. Record review of Resident #1's care plan, with an admitted [DATE], indicated she had current skin conditions. The skin conditions were marked as surgical incision, surgical wound and open lesions other than stasis/venous areas. Interventions included monitoring for and treating pain per physician orders and record findings in the clinical record. Record review of Resident #1's order summary report dated 10/01/22 to 10/30/22, indicated active orders as of 11/07/22 included an order to administer hydrocodone/acetaminophen 7.5mg-325mg one tablet by mouth every 6 hours as needed for pain. Record review of Resident #1's October MAR, indicated she received hydrocodone/acetaminophen twice on 10/01/22 at midnight by LVN M and at 4:22 p.m. by LVN H, twice on 10/02/22 at 12:40 a.m. by LVN H and at 7:50 p.m. by LVN H and twice on 10/03/22 at 1:13 p.m. by RN F and 8:06 p.m. by RN F. No administration was documented on 10/04/22, 10/05/22, 10/06/22 or 10/07/22. Record review of the facility investigation of the medication misappropriation from 10/08/22, indicated all nurses who had worked on Resident #1's medication cart recently, were required to drug test. LVN M refused to drug test and became irate, stating she was being accused of something. All other staff drug tests were negative. LVN M was terminated on 10/08/22 for being late to work on 10/04/22, not coming in or calling in to work on 10/07/22 and then refusing to drug test on 10/08/22. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 hall over the weekend had to be tested , but not the whole staff. LVN A said there was an agency nurse who had 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 refilled for that resident around 9 days before. 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 he got a text on 10/08/22 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 for her on 09/29/22 for 120 pills. He had to refill the prescription again because the facility had no hydrocodone 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 told agency LVN C to call the physician. One of the double weekend nurses called the pharmacy for them, and 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 count was correct for all medications that were in the lockbox. She said she and the CNA (she did not remember who the aide was) went into Resident #1's room because she was screaming. She said they repositioned her and it still did not help. She said the resident did not ask for pain medicine, but she was still going to provide 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 the physician, to which he said he had just ordered some for her recently. She said she then told the weekend supervisor. She said the RN supervisor looked all over the building and in all the other carts and did not find the hydrocodone. She notified the physician that the RN supervisor had not found the medicine and it did not 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) did 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 late to 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 to 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. (continued on next page)

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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) .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656 Based on interview and record review, the facility failed to ensure treatment and care was provided based on the comprehensive assessment and in accordance with standards of practice for 1 of 6 residents reviewed for quality of care. (Resident #1) 1. 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 pressure 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 residents at risk for not receiving necessary care and services to meet their needs, serious impairment, and death. 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 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) kidney 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 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 [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 wounds. Record review of Resident #1's baseline care plan, completed on [DATE] by the interim-DON indicated she had no wounds or skin alterations. (continued on next page)

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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]. Record review of Resident #1's admission assessment, dated [DATE] and completed by LVN A, indicated she had a surgical incision to her upper-mid vertebrae, a pressure wound to the outer side of her left foot and the inner side of her left foot. The assessment did not indicate the size or condition of the wounds. 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. Record review of Resident #1's electronic chart throughout the duration of the investigation between [DATE] to [DATE] revealed no other weekly skin assessments during her stay in the facility. 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 her 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 dated [DATE] indicated Resident #1 yelled out all shift on the day shift. The night shift indicated she had osteomyelitis of the vertebra. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a nurse's note, written by LVN A and dated [DATE] at 3:27 p.m., indicated Resident #1 had nausea and vomiting caused by coughing. A COVID test was conducted, and she was found to be positive. Isolation and contact precautions were to be initiated. 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 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 [DATE], 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 shift. The report did not contain any information regarding the resident's wounds to her feet or back. Record review of the 24-hour report dated [DATE], during Resident #1's COVID isolation, indicated they were still awaiting the x-ray to her spine. The report did not contain any information regarding the resident's wounds to her feet or back. Record review of the 24-hour report book on [DATE] at 4:00 p.m., revealed no other COVID wing 24-hour reports except for [DATE], [DATE] and [DATE]. Record review of a nurse's note, written by agency LVN D and dated [DATE] at 3:26 a.m., indicated Resident #1 was continuing to yell out, banging on the walls, and yelling for staff to help her. LVN D indicated 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 [DATE], 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 [DATE] at 12:00 p.m., indicated Resident #1 was readmitted to the facility on hospice services. She was described as having discoloration to her heels, the dehisced wound over her lumbar vertebrae, and two open areas to her buttocks. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. During an interview on [DATE] at 2:10 p.m. 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. 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]. During an interview on [DATE] at 3:52 p.m. CNA E said she had worked with Resident #1 on the COVID hall. She denied observing any wounds on her back because on the COVID hall the resident would scream when touched and she would not turn all the way over. She said the night she found the wound on her back, [DATE], the resident had been complaining of pain from not having a bowel movement. The nurse gave the resident 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 felt the wetness from her wound and thought it was a bowel movement. She said she initially thought it was a bowel movement as well, until she rolled the resident all the way over and saw the wound. The wound was purple and covered by the flaps of skin due to her obesity. 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 minor touch. She said the drainage was chunky and gritty and was a yellowish-green tint, like a snot color, and it smelled. She said agency LVN B was unaware of the wound and looked in the chart to see if any wound care had been ordered for the wound but did not find any. She said LVN B sent the resident out because of the state of the wound. She said before the resident went to the hospital, she was cognitive and knew the aide's name and was with it, but after the hospital she did not know anyone and was no longer cognitively intact and would just holler out for help. 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)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] 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 [DATE], 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 [DATE]. During a phone interview on [DATE] at 10:36 a.m. the ID physician said she had wanted the resident to follow up with her, but that never happened. She was unsure why a follow up never happened, whether it was due to hospital error, facility error, or even family error. She said she could not recall what the wound looked or smelled like at the hospital when she arrived for treatment. During an interview on [DATE] 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 resident had a surgical incision over her spine. When the resident arrived at the facility, she had a dressing over the incision. The nurse did not take off the bandage because she was told wound care had been done before the resident left the hospital. She did a thorough head to toe skin assessment and noted the resident had the wound to her spine and two wounds to her feet. She said the hospital did not say anything about what kind of wound care orders they had in place at the hospital or anything about the resident following up with a physician. She said when she saw the wounds to the resident's feet and back, she should have put the orders in for wound care, but she gave all the paperwork to the ADON. The ADON said she would put all the orders in, and the oncoming shift could take care of the rest. During an interview on [DATE] at 2:55 p.m. agency LVN D said she did not remember seeing any wound care orders for Resident #1 and did not remember seeing any wounds when she would do incontinent changes for her on the COVID wing. She said the resident was bad at turning and could not turn all the way over. During a phone interview on [DATE] at 4:00 p.m. agency LVN H said she did not remember Resident #1 having wounds while she worked the COVID wing. During a phone interview on [DATE] at 4:05 p.m. agency LVN J said she did not ever remember doing wound care on Resident #1 while she worked the COVID wing. During a phone interview on [DATE] 4:10 p.m. agency LVN K said she could not say for sure if Resident #1 had wounds while she worked the COVID wing. She said she just remembered the resident yelling out and when they would go in her room, she would say she had not been yelling and did not need anyone to come in there. (continued on next page)

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	675602	A. Building B. Wing	11/09/2022

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

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(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	During an interview on [DATE] at 4:25 p.m. with the ADON and interim-DON, the ADON said she was not aware of Resident #1 having any wounds to her feet but did know she had a wound to her spine. She said she helped LVN A put the orders in and since she did not see any orders for wound care or for following up with a physician, she did not put any in. The ADON and the interim-DON said they were both unaware no one followed up on getting her wound care or to follow up with a physician. The interim-DON said she could not find the resident's x-ray of her back and it appeared the x-ray was never obtained. During a phone interview on [DATE] at 10:30 a.m. Resident #1's Physician said he was not aware of the resident not receiving wound care to her feet or her back. He said he had not received the results of the x-ray to her back and had not been aware the x-ray was not obtained. He said had he known all this information, he would have made sure staff were giving her the ordered antibiotics, obtained the spinal x-ray, and gotten her into the ID for follow up. He said he believed she was seen by (ID physician's name) and was not aware the facility had never made a follow up appointment. During a phone interview on [DATE] at 10:19 a.m. agency LVN C said she did not remember if Resident #1 had wounds anywhere on her body. She said the resident would not let them turn her all the way over, so she did not know if the resident had any wounds to her back. She said the physician did order an x-ray for the resident's lumbar spine on [DATE] since she was complaining of pain to her there. She said the resident said she had pain to her back but then would not let them reposition her or turn her all the way over. She said she worked the 6a to 2p shift on [DATE] and then had to come back to work a 10p to 6 a shift. She said when she came back that night, she saw where the x-ray result was not received so she called the x-ray company to see where the results were. She said when she called the x-ray company , the on-call operator said the system had been out and he was not able to see anything on his end but would send a message to the x-ray technician. She said the technician never came on her shift and she notified the 6a to 2p nurse, the morning of [DATE] that the x-ray technician had not come and to call and follow up with the x-ray company about getting it done that day. During a phone interview on [DATE] 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. Record review of the facility's Change in a Resident's Condition or Status policy indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care .resident rights, etc.) . Policy Interpretation and Implementation 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; . .g. need to transfer the resident to a hospital/treatment center; . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Immediate Jeopardy (IJ) was identified on [DATE] 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 [DATE] at 1:09 p.m. During an interview on [DATE] at 1:09 p.m. with the interim-DON, ADON and Administrator, the interim-DON and ADON both indicated they had not been aware of Resident #1's skin assessment on [DATE] not reflecting her wounds. The interim-DON said she documented the resident had no skin alterations because she did not know the resident had any skin issues. She said she could only go by what the LVN A had documented, and she didn't see any documentation about wounds. 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 [DATE] and was not approved by her until [DATE]. The following Plan of Removal submitted by the facility was accepted on [DATE] at 8:52 a.m. and included the following: [DATE] 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. Audit of all medications compared to current orders for all residents in house was completed on [DATE] to ensure that no other residents have missed medications. Director of Clinical Operations, Assistant Director of Clinical Operations, Clinical Reimbursement Coordinator and Treatment Nurse reviewed clinical records for residents with wounds to ensure documented notification of family and physician. Director of Clinical Operations, Assistant Director of Clinical Operations, will review all x-rays ordered with over the last six months to ensure follow thru and notification of findings. The Director of Clinical Operations, Assistant Director of Clinical Operations, Treatment Nurse and All Licensed Nurses will be provided in-service education related to Notification of Change, including any signs and symptoms of worsening infections beginning on [DATE] by Director of Clinical Operations or designee 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. 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)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Physician must be notified of any wounds present on admission or readmission and or wound orders within 2 hours of admission or re-admission via phone. 4. Physician to be notified of any change in medical conditions including worsening infections, falls, or medical changes withing 2 hours of assessment. See Monitoring form for changes in condition attached. The Director of Clinical Operations, Assistant Director of Clinical Operations, Treatment Nurse, and licensed nurses to be provided education on following physician's orders as it pertains to x-ray services on [DATE] by Director of Clinical Operations or designee which includes: 1. Nurses must complete orders as written. 2. If an order is not or cannot be complete physician must be notified via phone within 2 hours of receiving notification. 3. Each shift must follow up on x-ray orders until results are obtained. 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. Director of Clinical Operations or designee will review records for any newly admitted or readmitted resident daily in clinical meeting to ensure physician notification and appropriate follow up. Beginning [DATE]. Director of Clinical Operations or designee will review all x-ray order daily in the clinical meeting to ensure x-rays are obtained and physician notification is completed. Admission check list form is to be completed by admitting nurse to ensure appropriate notification and completion of assessments to be initiated within 2 hours of admission. See form attached. Change in conditions check list to be utilized to ensure nurse competency with completion of assessments and physician notification. Beginning [DATE]. On [DATE] from 11:40 a.m. to 2:50 p.m. the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: 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. Record review of A Midnight Census Report dated [DATE] at 3:18 PM, by the interim-DON showed 37 Residents had been checked off as being reviewed by the DON for narcotics and all medications. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review between 12:47 p.m. and 1:15 p.m. of staff who had received training, indicated 12 staff had been educated over the phone and stated their understanding of the education provided. During an interview on [DATE] at 12:47 p.m., the interim-DON said she conducted a full sweep of all 37 residents to ensure there were no new skin issues. She said she also reviewed all medications to ensure each resident had orders and medication available. The interim-DON said she also assessed each resident for pain. The interim-DON said all residents were to have a skin assessment on admission or re-admission within 2 hours. She said all nursing staff had been trained on skin assessments. She said nurses had also been trained on monitoring antibiotics for the duration of the schedule and 3 days after for any reactions. She said nurses were to notify the DON any time antibiotics are ordered. She said she is the Infection Control Preventionist for the facility at the time, until the new wound care nurse completes her training, then the new 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 documented new orders on the report. The Administrator and DON were informed the Immediate Jeopardy was removed on [DATE], at 2:50 p.m. The facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656 Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents, for 1 of 6 residents reviewed for medication regimen. (Resident #1) The facility failed to ensure Resident #1 was given her indefinitely prescribed doxycycline between 09/27/22 and 10/18/22 and again between 10/21/22 and 10/26/22. 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: 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. 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 100 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. (continued on next page)

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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 10/28/22 included the following orders: *doxycycline monohydrate 100mg capsules twice a day and give long term, ordered on 9/27/22 and an end date of 10/03/22. *doxycycline hyclate 100mg tablet twice a day was ordered on 10/21/22 and ended on 10/21/22. *doxycycline monohydrate 100mg capsules twice a day was ordered on 10/21/22 with a start date of 10/26/22. *an x-ray to her lumbar spine for severe pain was ordered on 10/08/22 and ended on 10/11/22. Record review of Resident #1's September MAR, indicated she did not receive doxycycline monohydrate through 09/01/22 to 09/30/22. 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 p.m. of the facility drug destruction log revealed no record of Resident #1's doxycycline being destroyed within the past month. Record review of the 24-hour report dated 09/27/22 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 dated 09/29/22 indicated Resident #1 yelled out all shift on the day shift. The night shift indicated she had osteomyelitis of the vertebra. Record review of the 24-hour report dated 09/30/22 revealed no report found. 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)

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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. During an interview on 11/01/22 at 3:52 p.m. CNA E said she had worked with Resident #1 on the COVID hall. She said the night she found the wound on her back, 10/18/22, the resident had been complaining of pain from not having a bowel movement. 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 felt the wetness from her wound and thought it was a bowel movement. She said she initially thought it was a bowel movement as well, until she rolled the resident all the way over and saw the wound. The wound was purple and covered by the flaps of skin due to her obesity. 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 minor touch. She said the drainage was chunky and gritty and was a yellowish-green tint, like a snot color, and it smelled. She said agency LVN B was unaware of the wound and looked in the chart to see if any wound care had been ordered for the wound but did not find any. During a phone interview on 11/01/22 a 4:30 p.m. agency LVN B said when she pulled Resident #1's skin back, dark brown drainage poured out of the wound over her spine. 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 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. (continued on next page)

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F 0755 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 signed for therapeutic interchanges to be made whenever an order was put in for a wrong medication. For example, if the doctor ordered doxycycline monohydrate and staff entered doxycycline hyclate, the system would kick out the order for hyclate and enter a new order for the monohydrate, which an RN must approve. She said the corporate office was usually the one that requested the therapeutic interchanges and if one facility under the corporation did it then most likely all facilities under that corporation did. She said there were different 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 changed it to doxycycline monohydrate capsules. She said they sent out 60 pills that day. The next order for them came in on 10/21/22, they did not send any out because the refill was too soon from the last fill date. During a phone interview on 11/02/22 at 10:36 a.m. the ID physician said she was told by the family and Resident #1, at the hospital, that she had not been receiving antibiotics at the facility. She said she did give an order for the resident to have indefinite doxycycline at the facility, but since she did not go to the 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 if she had given the initial dose of the resident's doxycycline, she would have followed up on it for 72 hours, so if there were no notes following up on it, then she did not administer it. During a phone interview on 11/03/22 at 4:00 p.m. agency LVN H said she did not remember the resident being on an antibiotic while she worked the COVID wing. During a phone interview on 11/03/22 at 4:05 p.m. agency LVN J said she did not remember if the resident was on an antibiotic or not. During a phone interview on 11/03/22 4:10 p.m. agency LVN K said she did not remember if the resident took an antibiotic. She said she just remembered the resident yelling out and when they would go in her room, she would say she had not been yelling and did not need anyone to come in there. During an interview on 11/03/22 at 4:25 p.m. with the ADON and interim-DON, the ADON said she was not aware of Resident #1 having any wounds to her feet but did know she had a wound to her spine. She said she helped LVN A put the orders in and since she did not see any orders for wound care or for following up with a physician, she did not put any in. The ADON and the interim-DON said they were unaware the pharmacy kept kicking out the doxycycline orders and the LVNs could not see the orders were being kicked out automatically and then resubmitted. They both denied knowing about the resident not receiving her antibiotics until 10/26/22. The interim-DON said she could not find the resident's x-ray of her back and it appeared the x-ray was never obtained. During a phone interview on 11/04/22 at 10:30 a.m. Resident #1's Physician said he was not aware of her not receiving her doxycycline. He said had he known this information, he would have made sure staff were giving her the ordered antibiotics. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 submitted by the facility was accepted on 11/06/22 at 8:52 a.m. and included the following: 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. Audit of all medications compared to current orders for all residents in house was completed on 11/05/22 to ensure that no other residents have missed medications. Director of Clinical Operations, Assistant Director of Clinical Operations, Clinical Reimbursement Coordinator and Treatment Nurse reviewed clinical records for residents with wounds to ensure documented notification of family and physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675602	A. Building B. Wing	11/09/2022

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

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(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, Assistant Director of Clinical Operations, will review all x-rays ordered with over the last six months to ensure follow thru and notification of findings. The Director of Clinical Operations, Assistant Director of Clinical Operations, Treatment Nurse and All Licensed Nurses will be provided in-service education related to Notification of Change, including any signs and symptoms of worsening infections beginning on 11-4-22 by Director of Clinical Operations or designee 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. 2. Physician must be notified of any missed dosages of medication as prescribed no later than 3 missed doses as per policy. See attached. 3. Physician must be notified of any wounds present on admission or readmission and or wound orders within 2 hours of admission or re-admission via phone. 4. Physician to be notified of any change in medical conditions including worsening infections, falls, or medical changes withing 2 hours of assessment. See Monitoring form for changes in condition attached. The Director of Clinical Operations, Assistant Director of Clinical Operations, Treatment Nurse, and licensed nurses to be provided education on following physician's orders as it pertains to x-ray services on 11-4-22 by Director of Clinical Operations or designee which includes: 1. Nurses must complete orders as written. 2. If an order is not or cannot be complete physician must be notified via phone within 2 hours of receiving notification. 3. Each shift must follow up on x-ray orders until results are obtained. 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. Director of Clinical Operations or designee will review records for any newly admitted or readmitted resident daily in clinical meeting to ensure physician notification and appropriate follow up. Beginning 11-7-22. Director of Clinical Operations or designee will review all x-ray order daily in the clinical meeting to ensure x-rays are obtained and physician notification is completed. Admission check list form is to be completed by admitting nurse to ensure appropriate notification and completion of assessments to be initiated within 2 hours of admission. See form attached. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675602	A. Building B. Wing	11/09/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Change in conditions check list to be utilized to ensure nurse competency with completion of assessments and physician notification. Beginning 11-7-22. On 11/06/22 from 11:40 a.m. to 2:50 p.m. the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: 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. Record review of A Midnight Census Report dated 11/05/22 at 3:18 PM, by the interim-DON showed 37 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 had 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 37 residents to ensure there were no new skin issues. She said she also reviewed all medications to ensure each resident had orders and medication available. The interim-DON said she also assessed each resident for pain. The interim-DON said all residents were to have a skin assessment on admission or re-admission within 2 hours. She said all nursing staff had been trained on skin assessments. She said nurses had also been trained on monitoring antibiotics for the duration of the schedule and 3 days after for any reactions. She said nurses were to notify the DON any time antibiotics are ordered. She said she is the Infection Control Preventionist for the facility at the time, until the new wound care nurse completes her training, then the new 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 documented new orders on the report. The Administrator and DON were informed the Immediate Jeopardy was removed on 11/06/22, at 2:50 p.m. The facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.