

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455591	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2024
NAME OF PROVIDER OR SUPPLIER  Focused Care of Waxahachie		STREET ADDRESS, CITY, STATE, ZIP CODE  1413 W Main St Waxahachie, TX 75165	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700</b></p> <p>Based on observation, interview and record review the facility failed to develop a comprehensive care plan of each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for three (Residents #3, #4 and #5) out of eleven residents reviewed for care plans.</p> <p>The facility failed to develop a comprehensive care plan for Resident #3, #4 and #5 in order to provide care in that:</p> <p>Resident #3's care plan was blank,</p> <p>Resident #4's care plan was incomplete and had only one intervention for vaccine status,</p> <p>Resident #5's care plan was incomplete and had only two interventions for code status and alertness.</p> <p>This failure placed residents at risk of not having their individualized needs met in a timely manner and communicated to providers which could result in injury or a decline in physical well-being.</p> <p>Findings included:</p> <p>Review of Resident #3's face sheet dated 3/26/2024 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Type 2 Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebrovascular Disease and Heart Failure.</p> <p>Review of Resident #3's MDS dated [DATE] reflected a BIMS score of 15 suggesting no cognitive impairment.</p> <p>Review of Resident #3's EMR on 3/27/2024, reflected a blank care plan. There were no other care plans in the EMR.</p> <p>Review of Resident #4's face sheet dated 3/27/2024 reflected an [AGE] year-old female admitted on [DATE] with diagnoses including Dementia, Type 2 diabetes, and Hyperlipidemia (High cholesterol).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #4's MDS dated [DATE] reflected a BIMS score of 6 suggesting severe cognitive impairment.</p> <p>Review of Resident #4's EMR on 3/27/2024 reflected a care plan with one problem listed regarding her vaccine status [Resident #4] is up to date on the following vaccines: Covid Vaccine. This was the only intervention on the care plan and there were no other care plans in the EMR.</p> <p>Review of Resident #5's face sheet dated 3/27/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Traumatic Brain Injury, Hypertension, Anxiety Disorder, and Weakness</p> <p>Review of Resident #5's MDS dated [DATE] reflected a BIMS score of 15 suggesting no cognitive impairment.</p> <p>Review of Resident #5's EMR on 3/27/2024, reflected an incomplete care plan, having two problems: resident is alert and oriented. She provided verbal consent to date another resident in the facility and Resident request code status of FULL CODE. These were the only interventions in the care plan and there were no other care plans in the EMR.</p> <p>During an interview on 3/27/2024 at 10:15 am, the ADON was asked to pull up care plans for Resident #3, and #5. When asked what she saw, the ADON stated there is nothing there for one of them and the other only has 2 problems, none of which are nursing. She stated the problem with not having care plans was that's how we know how to care of the resident. She stated the admissions nurse was responsible for doing the base line care plan under the assessment tab and she thinks the MDS nurse was supposed to do the others. She stated they haven't had an MDS for a few weeks and she was not sure who was responsible right now. She stated, It could be a problem providing care for a resident without that information.</p> <p>During an interview and observation on 3/27/2024 at 10:46 am, the DON stated comprehensive care plans were the responsibility of the MDS nurse and she left two weeks ago. The DON stated she was hired last August, and care plans were behind then. She was observed pulling up care plans for Residents #3 and #5 and stated there was no care plan for Resident #3 and #5, only has 2 items.- She stated, that's incomplete and not good enough to provide care. She sated I'm not going to lie it was probably not done. She stated they haven't had an MDS nurse for a few weeks and she wasn't sure who was responsible right now.</p> <p>During an interview on 3/27/2024 at 1:25 pm with the AD, he stated he could not provide care plans for Resident #3, and #5 because they were not done. He stated care plans from February were either late, delayed on not done. He stated the MDS nurse at the time gave her notice the middle of February 2024 and he suspects she just checked out and did not do them. He stated at that time, it was the MDS nurse's responsibility for care plans but now they were supposed to be done by someone from corporate and I don't know why she hasn't been getting to them. He stated a problem with not having care plans completed was that helps them provide resident specific care.</p> <p>Review of Facility Policy Comprehensive Care Plan dated 4/25/2021 reflected Every resident will have an individualized interdisciplinary plan of care in place., and 3. The Comprehensive care plan is developed within 21 days of admission.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44700</p> <p>Based on record review and interview, the facility failed to ensure that all drugs and biologicals were properly stored and inaccessible to unauthorized staff and residents for one resident (Resident #2) of four residents reviewed for medication storage.</p> <p>The facility failed to ensure narcotics were received and then stored in a manner to prevent diversion on 03/04/2024 when a refill of Hydrocodone, 10-325 milligrams, quantity of 75, for Resident #2 was received from the pharmacy by LVN A, given to LVN B on 3/4/2024 and discovered missing on 03/06/2024.</p> <p>This failure could place residents at risk for drug diversion and access to medications that could cause harm, sickness, or hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #2's face sheet dated 3/26/2024 reflected an eighty-three-year-old male admitted on [DATE] with diagnoses that included: Senile Degeneration of Brain (gradual loss of thinking ability), Hypertension (high blood pressure), Dementia (progressive loss of intellectual functioning), Shoulder pain, and a History of Falls.</p> <p>During an interview on 3/26/2024 at 3:32 pm, the AD stated a card of hydrocodone medication, and the narcotic sheet were discovered missing on 3/6/2024. He stated he had reviewed video coverage from 3/4/2024 and could see that LVN A handed the cards of medications from a recent delivery to LVN B. He stated after that the staff walked out of video range. He stated an investigation was completed and the incident reported but was deemed inconclusive because no one saw LVN B take the medications. The AD stated all staff involved had completed a urine test and all tested negative.</p> <p>During an interview on 3/27/2024 at 2:22 pm, LVN A stated she had been working day shift on 3/4/2024. She stated just before shift change at 2:00 pm the pharmacy made a medication delivery, and she took the medications and signed for them. She stated she was sitting at the nurses station charting and had the medications with her when the oncoming nurse for the 2-10pm shift, LVN B came on shift. She stated she handed the medications to LVN B. She stated shortly after that, her and LVN B walked over to the nurse's medication cart for the 400/500 hall and completed a narcotic count, including the newly delivered narcotic medications. She stated she did not witness LVN B put the narcotic medications in to the cart. LVN A was asked if she was aware of the facility policy for receiving controlled substances required two nurses to witness placement of the controlled medication in the secure compartment of the medication cart and she stated Honestly, no, I was not aware of that. I did not watch her put them in the cart, so I'm not sure if she did nor not.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint interview on 3/27/2024 at 2:45 pm with the AD and DON, the DON stated on 3/6/2024 a pack of hydrocodone was identified as missing. All staff involved were interviewed and gave written statements. It was discovered that the medications were last in the possession of LVN B. The DON stated LVN B was interviewed and initially denied getting the meds, then stated she had handed them off to another staff. The DON stated LVN B refused to give a written statement to her. LVN B was suspended pending results of the investigation. The DON stated the resident did not miss any medication as they still some remaining and was assessed for any pain - none was reported. The DON stated she was not aware of the criteria of two nurse witnessing controlled substances being properly stored in the facility's current policy. The AD stated he expected his staff to follow facility policy when receiving medications from the pharmacy.</p> <p>LVN B was contacted by phone on 3/27/2024 at 3:22 pm and 4:02 pm and voicemails were left requesting a return call, but the calls were never returned.</p> <p>Review of Facility Incident Report dated 3/13/2024 revealed a card of Hydrocodone-APAP, 10-325 milligrams, quantity of 75 was discovered missing for Resident #2 on 3/6/2024. The incident report revealed the medication was received on 3/4/2024.</p> <p>Review of facility policy Receiving Controlled Substances dated 08-2020 revealed Policy: Medications classified by the Drug Enforcement Administration as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt and recordkeeping requirements by the facility in accordance with federal and state laws and regulations. Further the policy stated, 11. Only licensed personnel may receive controlled substances from the pharmacy courier. Procedures for receiving controlled substances include c. The receiving nurse transfers medications and accompanying inventory sheets to an authorized nurse on the unit (if different than the nurse who received the medication) or in accordance with facility policy, d. Two nurses, and/or in accordance with facility policy, witness placement of the controlled substance in the secured compartment of the medication cart.</p>		