

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 04/17/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526</p> <p>Based on observation, interview, and record review the facility failed to ensure adequate supervision and assistive devices to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents and supervision.</p> <p>The facility failed to ensure Resident # 1 was free from accidents. Resident # 1's leg was hit on a table by CNA A that resulted in a Tibial fracture to her right leg and was sent to the hospital for treatment services. The staff who caused the injury was moved to another hall.</p> <p>This failure placed residents at risk of being injured by CNA A.</p> <p>Findings included:</p> <p>Resident #1 was a [AGE] year-old female was admitted to the facility on [DATE] with diagnoses of Unspecified dementia (progressive or persistent loss of intellectual functioning, with impairment of memory and thinking), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Record review of Resident's #1 quarterly MDS dated [DATE] reflected Resident #1 has a BIMS score of 3 indicating severe impairment. Section GG functional ability reflected Resident # 1 was dependent for dressing, showering, putting on clothes, and toileting. Section J Health condition reflected Resident #1 had a history of falls and 1 fall since being admitted the facility.</p> <p>Record review of Resident #1 care plan dated 2/5/2024 reflected Resident #1 assessed for falls with interventions: Call light within reach, Fall mat beside bed.</p> <p>Record review of the facility progress note dated 4/8/2024 regarding an incident on 4/5/2024 by LVN D reflected the following:</p> <p>Resident #1 notified therapy that her right knee was hurting. Therapy placed ice on it. NP notified and gave orders for STAT right knee Xray. Xray ordered. Resident told therapy someone pushed me under the table and hit my knee.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an Interview on 4/16/2024 at 1:38pm with CNA A revealed she was pushing Resident # 1 up to the dining table and hit Resident # 1's leg on the table. CNA A stated she did not realize Resident #1 had her leg up, she stated the impact did not seem that hard, so she did not let the nurse know. CNA A stated she straightened out Resident #1's leg and pushed her up to the table. CNA A stated she later found out that Resident #1's leg had swelled up and there was a fracture. CNA A stated she was moved to another hall at the request of the family.</p> <p>During an interview on 4/16/2024 at 2:09pm with LVN A, stated on 4/5/2024 later that day Resident # 1 went to therapy. LVN A stated she was advised by therapy that Resident #1's knee was swollen and unable to bend. She stated they ordered x-rays 'Stat and found received the results the following day on 4/6/202, she stated the results indicated there was a fracture. LVN A stated Resident #1 was sent to the hospital for more treatment services. LVN A stated CNA A should have gotten a nurse at the time when she hit the resident's knee on the table.</p> <p>During an interview on 4/16/2024 at 3:50pm with the DCO, revealed she was made aware of the incident the next day when she was advised Resident #1 was sent out to the hospital. The DCO stated she was advised by LVN A, that Resident # 1 hit her knee and yelled out ouch. The DCO stated CNA A should have gotten the nurse to assess the resident at that time she hit her leg.</p> <p>During an interview on 4/16/2024 at 4:05pm with the EDO revealed there was no investigation completed because they were able to determine what happened. The EDO stated CNA A should have reported hitting Resident #1's leg to the nursing staff. He stated CNA A was moved from Resident #1's hall at the request of the family due a previous fall in which this staff was on duty. The EDO stated the family felt it would be best if she did not work on that hall anymore, so she was moved to another hall. The EDO stated they did not think that it was intentional by CNA A that she hit her leg and stated that was the extent of their investigation.</p> <p>Record Review of Resident # 1's hospital discharge medical records dated 4/6/2024. The medical records reflected Resident #1 was admitted to theER on [DATE]. The medical records reflected Resident #1 sustained a Tibial fracture to the right leg. The medical records reflected Resident # 1's right leg was placed in a splint and medication for pain was prescribed. Resident # 1 was released from the hospital later the same day on 4/6/2024 back to the facility.</p> <p>Record review of the facility Abuse/Neglect policy dated 2/1/2017, the policy reflected the following:</p> <p>Each resident has the right to be free from Abuse/Neglect</p> <p>Resident will not be subjected to abuse/neglect by anyone.</p> <p>Record review of facility Incident an Accident policy dated 3/1/2017 reflected the following:</p> <p>Accidents or incidents involving residents shall be investigated and reported to the EDO.</p>		