

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  10/18/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</b></p> <p>Based on interviews, observations, and record review, the facility failed to protect Resident #2's right to be free from physical, mental, and verbal abuse by Resident #1.</p> <p>The facility failed to protect Resident #1 from abuse by Resident #2. Residents had an established and repeated facility wide known history of disputes, both verbal and attempted physical alterations. On 10/09/2024, both residents were in the same room unattended by staff and video footage revealed Resident #1 used his cane to hit Resident #2 on the head. Resident #2 was sent to the hospital by EMS and received 10 staples to his head for a 2 cm laceration.</p> <p>An IJ was identified on 10/12/24. The IJ template was provided to the facility on [DATE] at 1:45 PM. While the IJ was removed on 10/18/24, the facility remained out of compliance at a scope of pattern and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This failure placed residents at risk for abuse, injuries, and pain.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 10/11/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included diffuse traumatic brain injury (occurs when the brain is injured by blunt force, causing the brain's nerve fibers to shear or tear), depression and heart failure.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 08/27/24, reflected a BIMS score of 15 indicating intake cognition. On 10/11/24 at 12:30 pm observed Resident #1 ambulating using a wheelchair and had a cane with him, but neither device was listed in his MDS.</p> <p>Review of Resident #1's quarterly care plan reflected:</p> <p>Focus dated 03/18/24 Resident #1 had potential to have verbal and physical aggression related to anger.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Goal - the resident will demonstrate effective coping skills through the review date and the resident will not harm self or others through the review, date initiated 03/18/24, revision on 09/04/24, and target date 12/03/24.</p> <p>Interventions:</p> <p>Behavior plan in place with Resident - date initiated 03/18/24</p> <p>4. Get staff to mitigate any negative encounter and remove self from confrontation with Resident #2.</p> <p>5. Avoid contact with Resident #2 and not seek confrontation with Resident #2, and</p> <p>6. Monitor verbal or physical aggression every shift and document observed behavior attempted in behavior log</p> <p>On 10/11/24 at 12:30 pm observed Resident #1 ambulating using a wheelchair and had a cane with him, but neither device was listed in his care plan.</p> <p>Review of Resident #2's face sheet, dated 10/11/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type (which features bouts of mania and sometimes depression), and diffuse trauma brain injury (occurs when the brain is injured by blunt force, causing the brain's nerve fibers to shear or tear).</p> <p>Review of Resident #2's quarterly MDS assessment, dated 08/27/24, reflected a BIMS score of 14 indicating intact cognition. On 10/10/2024 at 4:18 pm observed Resident #2 in a wheelchair but this was not listed in his MDS.</p> <p>Review of Resident #2s quarterly care plan reflected:</p> <p>Focus:</p> <p>3. Resident #2 had behavior problems as a result of schizoaffective disorder - yelling, racial slurs, name calling</p> <p>4. 09/04/24 aggressive behaviors date initiated 12/15/23 revision on 09/05/24</p> <p>Goals:</p> <p>2. Resident #2 will have less than daily behaviors hitting self. Impulsiveness, racial slurs by review date</p> <p>Date initialed 12/15/23, revision date 03/04/24, and target date 12/09/24</p> <p>Interventions:</p> <p>4. administer medication as ordered, monitor/document for side effects and effectiveness date initialed 12/15/23</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's progress note dated 08/08/24 reflected nurse went to dining room due to hear Resident #1 yelling. Upon entering the dining room Resident #1 was in his wheelchair yelling at a CNA about Resident #2. It was alleged that Resident #1 spit in the face of Resident #2. Resident #1 stated, yeah I spit on him because he [Resident #2] cusses at me. Resident was spoken to and encouraged to calm down and stop yelling and not to spit on others regardless of their activity. PMHNP, DON, and Administrator notified.</p> <p>Review of Resident #1's progress note dated 08/24/24 reflected Resident #1 was returned to facility by the police, police said they found him across the street where he called 911. Nurse asked resident what happened, and Resident #1 said he had called 911 because he was tired of having Resident #2, feeling like he can say anything he wants to me and I won't take it anymore so I went across the street and called the police on my phone. Nurse assured resident that measures have been taken to resolve this situation and will continue plan of care.</p> <p>Review of Resident #1's progress note dated 09/04/24 reflected CNA informed the nurse of an altercation between Resident #1 and Resident #2 in which Resident #2 kicked Resident #1's wheelchair and Resident #1 hit Resident #2 on the knee with his cane.</p> <p>Review of Resident #1's progress note dated 09/23/24 reflected nurse spoke with Resident #1 regarding issues he was having with Resident #2. Resident #1 stated he is not going to seek out Resident #2 and initiate behaviors, however, if Resident #2 provoked him he intended to finish it. Resident #1 was asked what he meant by this statement and Resident #1 stated that if Resident #2 provoked him he would, get him back. The nurse, who was the done DON, who wrote the progress note stated she also spoke with the PMHNP to initiate a behavioral care plan and contacted the ombudsman for assistance in developing a behavior plan.</p> <p>Review of Resident #1's progress note dated 10/09/24 reflected Resident #1 was assessed because of an altercation with Resident #2. Resident #1 stated that he had been hit in the face by Resident #2. Resident #1 assessed and found with no visible injury related to the incident. Note reflected there is a 2X1 (unit of measure not noted) slightly reddened area noted to the left side of residents left eye. Resident stated that Resident #2 hit him in the face, and he hit Resident #2 with his cane on the top of Resident #2's head. Resident #1 stated that the reddened area does not hurt, and he wasn't sure if that was related to the incident.</p> <p>Resident #2</p> <p>Review of Resident #2's progress note dated 09/04/24 6:23 PM reflected ambulance arrived at the facility and stated that they were called by resident #2. The nurse asked the resident why he called the ambulance and Resident #2 stated he got into an altercation with Resident #1 in the smoking area and his right knee hurt. Assessment of knee revealed no wound, no bleeding, or inflammation noted to the knee. Resident #2 insisted on being sent out and stated, if you don't let me go I'll cause hell to everyone here. The responsible party, ADON, DON, medical director, and Administrator were informed. Note reflected, will continue plan of care.</p> <p>Review of Resident #2's progress note dated 09/04/24 7:36 PM reflected police officer arrived at the facility and insisted on speaking to Resident #1 because of a report an altercation between him and Resident #2. Resident #2 called the police. There were no staff present when the altercation occurred.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's progress note dated 09/11/24 reflected Resident #2 continued 1 on 1 monitoring (reason for 1 on 1 monitoring not explained in note).</p> <p>Review of Resident #2's progress note dated 09/23/24 6:00 PM reflected resident seen for follow up virtual visit with PMHNP, Resident #2 was placed 1 on 1 due to having multiple on/off behaviors of aggression/agitation with other residents. Medication had been adjusted over the last two weeks. Resident #2 currently denies being a harm to himself or others. Staff reported that he has not had any noted agitation/aggression with him during one-to-one period and he denied harm to himself or others. Will discontinue 1 on 1 at this time and follow up with resident with face-to-face visit within one week.</p> <p>Review of Resident #2's progress note dated 09/23/24 8:00 PM reflected nurse spoke with resident regarding issues he was having with Resident #1. Resident #2 stated that he felt safe at this time and will do his best to stay away from Resident #1, the resident with whom he was having trouble with. The nurse spoke with the PMHNP regarding the safety of Resident #2 and she stated she had completed an assessment of him and the situation and in her opinion Resident #2 was not a danger to himself or others at this time. The facility was to provide a separate smoking areas Resident #1 and Resident #2 and to keep them separated as much as possible. The note reflected a discussion with the PMHNP to initiate a behavioral care plan and contact with the ombudsman for assistance in developing a behavior plan.</p> <p>Review of Resident #2's progress note dated 10/09/24 by LVN A reflected she heard someone yelling and went into the sunroom and noticed Resident #1 sitting behind resident #2. Resident #1 had his cane raised in the air. Resident #2 was leaning over and he had blood dripping from the top of his head. A second nurse (not identified in the note) went to get the DON, Administrator, and called 911. When the LVN A walked into the sunroom Resident #1 said Resident #2 hit him in the face and he hit Resident #2 on his head with his cane. Resident #2 stated Resident #1 called him a son of a bitch and told him not to talk about his mother. Resident #1 stated Resident #2 hit him in the face, and he hit Resident #2 with his cane. The police came and talked to Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of police report dated 10/09/24 reflected the DON advised the officer that Resident #1 and Resident #2 got into an altercation. DON stated that she was unaware of how the situation started but advised that Resident #1 and Resident #2 had several instances of verbal altercations and stated that they didn't like each other. Resident #2 had an open laceration on his head that was being treated. Resident #2 stated he and Resident #1 were in the sunroom by the smoking area when the incident occurred. Resident #2 said Resident #1 called him a son of a bitch which then caused him to punch Resident #1 using his right arm with a closed fist in the nose. The officer asked Resident #2 how hard he tried to punch Resident #1 and he said, As hard as he could. Resident #2 then stated that's when Resident #2 used his walking cane to hit him in the head, causing the open laceration. The officer observed the laceration on Resident #2's head. Resident #2 was transported to the hospital. The officer contacted the Administrator who provided him with camera footage of the incident. In the camera footage, the officer observed Resident #1 and Resident #2 in the sunroom by the smoking area. The officer observed that Resident #2 blocked the doorway path, trying to prevent Resident #1 from going to the smoking area. Resident #1 pulled on Resident #2's wheelchair, trying to pull him away from the door, and Resident #1 threw a closed fist punch (unsure if it connected with Resident #2), to which Resident #1 retaliated by hitting Resident #1 on the head with his walking cane. Resident #1 was asked to give his side of the story and he said Resident #2 wasn't supposed to be in that particular smoking area and Resident #1 was trying to get Resident #2 to leave by pulling on his wheelchair. Resident #1 stated they exchanged words and then got hit by Resident #2 under his left eye, which then caused him to hit Resident #2 with his cane. The officer then asked how hard he tried to hit Resident #1 and Resident #2 responded, saying, Well, it was enough to make him bleed. The officer observed redness under Resident #1's left eye.</p> <p>In an interview on 10/11/24 at 12:30 pm with Resident #1, he revealed the issues with Resident #2 had been ongoing for a while and Resident #2 had hit and kicked him several times. Resident #2 said he told Resident #1 he would knock him in the head if he did it again and that is what he did. Resident #1 said he warned Resident #2 a couple of days earlier and Resident #1 had been to the Administrator's office thirteen times and said that if Resident #2 hit him, he was going to hit Resident #2. Resident #1 said that Resident #2 was not supposed to be in the smoking area, and he told Resident #2 you are not supposed to be in the smoking area and Resident #2 hit across his face so Resident #2 knocked him in the head with his cane.</p> <p>In an interview on 10/11/24 at 4:18 pm with Resident #2, he revealed Resident #2 hit him over the head with a cane and it made him bleed.</p> <p>Interview on 10/11/24 at 1:04 pm, CNA B who revealed as far as she knew, Resident #1 and Resident #2 did not get along. Resident #2 called Resident #1 white trailer trash and Resident #1 did not let that go. CNA B said she observed Resident #1 and Resident #2 argue and they were separated. Resident #1 was on 1 on 1 because of an altercation with Resident #2. CNA B said when Resident #1 saw Resident #2, Resident #1 was on the defense. Staff were all supposed to keep an eye on Resident #1 and Resident #2. Sometimes Resident #2 would come into the group smoking area and Resident #1 would get upset and tell Resident #2 he could not be in that smoking area. CNA B said because of Resident #2's brain injury she was not sure if he understood he could not be in the community smoking area. CNA B said Resident #2 did not verbalize that he knew that he was not supposed to be in the community smoking area, and he did not 1/2 of the stuff he was told.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 10/11/24 at 2:27 pm with CNA C revealed staff told Resident #2 multiple times he could not be in the same area with Resident #1 because they always, bumped heads. Resident #2 was supposed to smoke on another hallway, but he insisted, everyday on going to the other hallway to smoke. CNA revealed Resident #2 went over to the community smoking area 15 or thirty minutes before the smoking time began. CNA C revealed Resident #2 went where he wanted to go and would say things to antagonize other people.</p> <p>Interview on 10/11/23 at 3:05 pm with CNA D revealed Resident #1 and Resident #2 should not have been alone and the Administrator did not want them to cross paths. Resident #1 was an aggressor and he and Resident #2 should not have been in a space together, alone, without supervision. Resident #2 would try to enter the community smoking area and she would tell Resident #2 you cannot be in this smoking area, and I will take you to smoke when I am finished here. CNA D revealed this happened several times a week. She said she reported this to the DON and ADON. She said she told the ADON and the DON it would be best if someone took Resident #2 out when she took the others out. If Resident #2 came out to the community smoking area, Resident #1 would cuss at Resident #2 and tell him you are not supposed to be out here and you are not allowed to be around me. Resident #2 could be on the complete opposite side of the building but if Resident #1 saw Resident #2, Resident #1, would see red.</p> <p>Interview on 10/11/24 at 4:59 pm with the ADON revealed they did their best to keep Resident #1 and Resident #2 apart. They were assigned separate smoking and eating areas. Resident #2 would go wherever he really wanted to go. There was a staff in-service that instructed that Resident #1 and Resident #2 should be kept separated. Resident #1 made it very clear he did not like Resident #2. The ADON said there was concern about them getting into an altercation, but she felt like the staff was keeping them separated.</p> <p>Interview on 10/11/24 at 12:30 pm DON who revealed Resident #1 and Resident #2 were in an altercation in the sunroom. Resident #1 came up behind Resident #2 and grabbed Resident #2's wheelchair and tried to pull Resident #2 away from the smoking area door. The video of the incident has no audio. Resident #1 hit Resident #2 over the head with his cane. There was no staff member present. There was a plan in place where Resident #2 was not supposed to be smoking at the same time as Resident #1. The residents were not supposed to be together. The staff had been in-serviced on keeping Resident #1 and Resident #2 separated, and it was care planned for each resident. The staff was aware of the residents' poor relationship. The residents were not on 1 to 1 supervision. The Residents had previous verbal altercations and one previous physical altercation. The DON thought the men did not like each other. Both men had a diagnosis of traumatic brain injury. Resident #2 received a significant injury to his head, a 2 cm laceration, when he was hit by Resident #1 with Resident #1's cane. The DON said Resident #2 could be impulsive.</p> <p>Review of the facility's abuse and neglect policy, undated 01/01/23, reflected:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The purpose of this policy is to ensure that each resident has the right to be free from any type of abuse The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policy and procedure. The facility administrator is the appointed abuse coordinator and in his/her absence a designee with be appointed. Abuse is willful infliction of injury or negligent, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident. Resident will not be subjected to abuse by anyone including but not limited to community staff, other residents The administrator and or designee are responsible for maintaining all facility policies that prohibit abuse, neglect, and misappropriation of funds/personal belongings. In the event of a resident-to-resident abuse, the facility will immediately protect the resident being abused and all other residents in the facility. If the initial determination is that the perpetrator is a threat to the health and safety of the residents in the facility as determined by the attending physician/or other physician, the resident will be discharged as soon as possible. During the time that the perpetrator has not been discharged , the facility will monitor this resident one-on-one to protect all other residents.</p> <p>The ADM was notified on 10/12/24 at 1:45 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.</p> <p>The following POR was accepted on 10/17/24 at 4:05 PM:</p> <p>Plan of Removal</p> <p>On 10/12/2024 the surveyor provided an Immediate Jeopardy template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety.</p> <p>Removal of Immediacy Plan</p> <p>PLAN OF REMOVAL</p> <p>FOR</p> <p>IMMEDIATE JEOPARDY</p> <p>Impact Statement</p> <p>Abuse</p> <p>The resident has the right to be free from abuse, neglect misappropriation of resident property as defined in this subpart. This includes but is not limited to freedom from corporal punishment involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>Identify residents who could be affected</p> <p>All residents who came into contact with Resident #1 had the potential to be affected by this alleged deficient practice. All residents who come into contact with resident #2 has the potential to be affected by this alleged deficient practice.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Problem</p> <p>The facility failed to keep the residents free from abuse.</p> <p>Action Taken</p> <p>Resident #1 was placed on 1:1 and remained 1:1 until discharge. Resident #2 was placed on 1:1 until cleared by Psychology Nurse Practitioner. Administrator and Director of Nursing were in-serviced by Regional [NAME] President of Operations on 10-12-2024 to include keeping resident within eyesight at all times and maintaining resident safety. Staff members assigned to 1:1 will be in-serviced by Director of Nursing and/or designee on responsibilities to include keeping resident within eyesight at all times and maintaining resident safety. This in-service will occur prior to the start of each 1:1 shift. This will continue while resident remains 1:1. The administrator will oversee actions taken.</p> <p>Safe Surveys were conducted by administrative nurses/designee with alert and oriented residents to determine if there were any residents who did not feel safe in the facility. Safe survey did not reveal any additional resident that cause fear or abuse. Verification of completion on 10-12-2024 was done by the Administrator. For those non-alert and non-oriented residents all nurses have been educated on 10-13-24 to monitor for changes in behavior and skin during weekly skin assessments for non-verbal signs and symptoms of abuse this will continue indefinitely. All new nurses will be trained during orientation.</p> <p>The Director of Nursing and/or designee began educating all staff on the facility's Abuse and Neglect policy on 10-12-2024. All staff will be educated prior to their next assigned shift. Training will continue until all staff have been educated by 10-13-2024. All new staff will be trained during orientation. Agency staff are not used in the facility.</p> <p>The Director of Nursing and/or designee began educating all clinical staff on following resident #2 plan of care on 10-12-2024. All clinical staff will be educated prior to their next assigned shift. Training will continue until all clinical staff have been educated by 10-13-2024. All new clinical staff will be trained during orientation. Agency staff are not used in the facility.</p> <p>Involvement of Medical Director and Quality Assurance</p> <p>Ad HOC QA meeting held with the medical director on 10-12-2024 to review all aspects of Immediate Jeopardy and Initial Plan of removal.</p> <p>QA meetings are held on a monthly basis and all allegations, incidents, and accidents will be reviewed during the QA meeting. The next QA meeting will be 11-12-2024. This will be an ongoing process.</p> <p>Monitoring:</p> <p>Reviewed facility documentation that Resident #1 was placed on 1:1 and remained 1:1 until he was discharged from the facility on 10/11/24. Reviewed documents that Resident #2 was placed on 1:1 until cleared by Psychology Nurse Practitioner. Resident #2 1:1 monitoring still continued at time of investigator exit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Reviewed facility Safe Surveys that were conducted by administrative nurses/designee with alert and oriented residents to determine if there were any residents who did not feel safe in the facility. The reviewed safe surveys did not reveal any additional resident that caused fear or abuse.</p> <p>On 10/18/2024 reviewed nursing staff in-services dated 10/13/23 that provided education for non-alert and non-oriented residents to monitor for changes in behavior and skin during weekly skin assessments for non-verbal signs and symptoms of abuse.</p> <p>On 10/18/24 reviewed in-services that provided education for all staff on the facility's Abuse and Neglect policy dated 10/13/24 including types of abuse, reporting, who the facility abuse and neglect coordinator was, and signs of abuse.</p> <p>On 10/18/24 reviewed in-serves confirming DON trained and informed staff that 1 to 1 for resident is 24-7 and the staff were trained to make sure resident was in eyesight for safety.</p> <p>Staff members assigned to 1:1 will be in-serviced by Director of Nursing and/or designee on responsibilities to include keeping resident within eyesight at all times and maintaining resident safety. Staff interviewed confirmed this in-service occurred prior to the start of each 1:1 shift and will continue while resident remains 1:1.</p> <p>In an interview with the DON on 10/18/24 11:40 AM the DON stated all training was completed with staff on 10/13/24 on abuse neglect. Any PRN staff will be trained prior to working shift they are scheduled for. She trained and informed staff that 1 to 1 for resident is 24-7 and the staff were trained to make sure resident was in eyesight for safety.</p> <p>In an interview on 10/18/24 2:15 PM with RVP he stated he in-serviced the Administrator and the DON on 10/12/24 on facility abuse neglect policy.</p> <p>In an interview with the DON on 10/18/24 at 11:40 PM she revealed she was in-serviced by the RVP on different types of abuse/neglect including types of abuse (mental, physical, and verbal) and to report to the Administrator immediately if she ever witnessed any abuse.</p> <p>In an interview on 10/18/24 2:15 PM with RVP he stated he in-serviced the Administrator and DON regarding 1:1 supervision to include keeping resident within eyesight at all times and maintaining resident safety.</p> <p>In an interview on 10-18-2024 at 12:15 PM with CNA E she stated she had been 1 to 1 with Resident #2 since 8:00 AM that morning and will continue to be 1 to 1 until the end of her shift at 10:00 PM. CNA E stated that Resident #2 was to have 1 to 1 24-7. CNA E stated she had signed off on training by the DON on 10-16-2024 on abuse and neglect training and understood that during the 1 to 1 for Resident #2 she needed to make sure he was always in view(eyesight) for the resident safety. She was trained on abuse neglect and knew the different types (mental, physical, and verbal), the signs of abuse (bruises and emotional changes or indicators) and knew to report immediately to the abuse coordinator (ADM) if ever witnessed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During interviews on 10/18/24 from 11:40 AM - 3:50 PM, one RN, three LVNs, and five CNAs (from different shifts) all stated they were in-serviced and abuse and neglect. All were able to state that the Administrator was the Abuse and Neglect Coordinator and give examples of different types of abuse such as physical, verbal, emotional, and psychosocial. All stated if they saw a resident being abused by a staff member, another resident, or a family member they would intervene to ensure the resident was in a safe space and would notify the Administrator immediately. They all stated if the Administrator or DON was not immediately available, they would call the HHSC hotline (and were able to report where the number was posted). They all stated it was important to notify the Administrator because a thorough investigation was necessary to ensure residents safety, and report to the appropriate agencies.</p> <p>Reviewed documentation of Ad HAC QA meeting attended by the DON, Administrator, the MD, confirming review all aspects of Immediate Jeopardy and Initial Plan of removal including in-serving in progress and procedural changes made moving forward.</p> <p>While the IJ was removed on 10/18/24 at 5:00 PM, the facility remained out of compliance at a scope of pattern and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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**</b> 46708</p> <p>Based on interviews, observations, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for two (Resident #1 and Resident #2) of ten residents reviewed for care plans.</p> <p>The facility failed to implement a comprehensive care plan for Resident #1 and Resident #2 with attainable interventions in place addressing the repeated facility wide known history of disputes between the two Residents. An incident occurred on 10/09/24 where video footage revealed R#1 used his cane to hit Resident #2 on the head. Resident #2 was sent to the hospital by EMS and received 10 staples to his head for a 2 cm laceration.</p> <p>An IJ was identified on 10/16/24. The IJ template was provided to the facility on [DATE] at 12:48 PM. While the IJ was removed on 10/18/24, the facility remained out of compliance at a scope of pattern and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This failure placed residents at risk for not including measurable objectives and timetables to meet residents' medical, nursing, and mental and psychosocial needs to ensure resident safety.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 10/11/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included diffuse traumatic brain injury (occurs when the brain is injured by blunt force, causing the brain's nerve fibers to shear of tear (a force that acts in opposite directions, causing a tear or deformation)), depression, and heart failure.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 08/27/24, reflected a BIMS score of 15 indicating intake cognition No information was provided in section E regarding Resident #1's behavior and did not include information about physical or verbal behaviors directed at others.</p> <p>On 10/10/24 at 12:20 pm observed Resident #1 ambulated using a wheelchair and he had a cane, but neither device was listed in his MDS.</p> <p>Review of Resident #1's quarterly care plan reflected:</p> <p>Focus dated 03/18/24 Resident #1 had potential to have verbal and physical aggression related to anger.</p> <p>Goal - the resident will demonstrate effective coping skills through the review date and the resident will not harm self or others through the review, date initiated 03/18/24, revision on 09/04/24, and target date 12/03/24</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interventions:</p> <p>Behavior plan in place with Resident - date initiated 03/18/24</p> <ol style="list-style-type: none"> <li>1. Get staff to mitigate any negative encounter and remove self from confrontation with Resident #2.</li> <li>2. Avoid contact with Resident #2 and not seek confrontation with Resident #2, and</li> <li>3. Monitor verbal or physical aggression every shift and document observed behavior attempted in behavior log</li> </ol> <p>Review of Resident #1's progress note dated 03/17/24 revealed Resident #1 observed with another resident speaking harshly and using foul language, stating he was, Going to kick [Resident #2's] ass and making physical motions to indicate his intent. The nurse positioned herself in between the two residents and remained in between them at all times to prevent physical contact. Resident #1 refused to move away from Resident #2. Resident #1 repeatedly moved himself closer to Resident #2 even when asked not to and he was continuing to taunt and threaten Resident #2. Nurse removed Resident #2 from the area and brought him with her to monitor Staff was made aware of the situation and alerted to keep residents apart due to aggressive behaviors. DON and</p> <p>Administrator notified of situation.</p> <p>Review of Resident #1's progress note dated 03/18/24 reflected social worker followed up with resident to address an altercation with Resident #2 that happened over the weekend. Resident shared his version of the story. Social worker listened and provided ways to avoid altercations. Resident listened and agreed.</p> <p>Review of Resident #1's progress note dated 03/25/24 social worker and administrator spoke with resident regarding a conflict he had previously with Resident #2. Resident stated that he needed time space to deal with his feelings. Resident will be given time and space as requested. Social worker will follow up with Resident #1 weekly to check on him.</p> <p>Review of Resident #1's progress note dated 04/05/24 reflected social worker spoke with resident to follow up. Resident shared that he and another resident [Resident #2] made amends. Resident #1 stated that he forgave Resident #2 because he had to do it for himself.</p> <p>Review of Resident #1's progress note dated 04/05/24 reflected after dinner Resident #1 went outside behind the building and laid down on the grass. Staff attempted to talk to Resident #1 and he stated that he was going to come back inside but that he planned to stay out there until something was done to Resident #2. A call was placed to administrator and PMHNP and she recommended to call non-emergency police and see if they could talk him into coming inside. Police arrived and spoke with Resident #1 and he did come inside. The police asked the nurse what the plan was to keep him away from the man [Resident #2] Resident #1 was mad at. The plan was to place Resident #1 on every 15-minute checks to ensure he does not go near Resident #2 and smoke Resident #1 and Resident #2 away from each other.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's progress note dated 08/08/24 reflected nurse went to dining room because she heard Resident #1 yelling. Upon entering the dining room Resident #1 was in his wheelchair yelling at a CNA about Resident #2. It was alleged that Resident #1 spit in the face of Resident #2. Resident #1 stated, yeah I spit on him because he [Resident #2] cusses at me. Resident was spoken to and encouraged to calm down and stop yelling and not to spit on others regardless of their activity, PMHNP, DON, and Administrator notified.</p> <p>Review of Resident #1's progress note dated 08/24/24 reflected Resident #1 was returned to facility by the police, police said they found him across the street where he called 911. Nurse asked resident what happened, and Resident #1 said he had called 911 because he was tired of having Resident #2, feeling like he can say anything he wants to me and I won't take it anymore so I went across the street and called the police on my phone. Nurse assured resident that measures have been taken to resolve this situation and will continue plan of care.</p> <p>Review of Resident #1's progress note dated 09/04/24 reflected CNA informed the nurse of an altercation between Resident #1 and Resident #2 in which Resident #2 kicked Resident #1's wheelchair and Resident #1 hit Resident #2 on the knee with his cane.</p> <p>Review of Resident #1's progress note dated 09/23/24 reflected resident was seen by PMHNP by virtual visit. R had had incident where he was kicked and hit by Resident #2 and he hit Resident #2 with his cane. Both residents had to be separated and were taken to their rooms. PMHNP discussed the incident with Resident #1 and he stated facility staff seem to be keeping Resident #2 away from him so Resident #1 felt safe. Resident #1 said that he felt if the facility staff let him [Resident #2] loose Resident #2 would go back to being himself. Resident #1 said Resident #2 hit him five times, cursed at him 10 times, and shot the finger at him until he had no choice but to result to violence. The note reflected the DON was told about the conversation and the DON agreed to put a plan in place to help Resident #1 feel safe and to prevent further incidents.</p> <p>Review of Resident #1's progress note dated 09/23/24 reflected nurse spoke with Resident #1 regarding issues he was having with Resident #2. Resident #1 stated he is not going to seek out Resident #2 and initiate behaviors, however, if Resident #2 provokes him he intends to finish it. Resident #1as asked what he meant by this statement and Resident #1 stated that if Resident #2 provoked him he would, get him back. The nurse, DON, who wrote the progress note stated she also spoke with the PMHNP to initiate a behavioral care plan at this time and contacted the ombudsman for assistance in developing a behavior plan.</p> <p>Review of Resident #1's progress note dated 10/09/24 reflected Resident #1 was assessed because of an altercation with Resident #2. Resident #1 stated that he had been hit in the face by Resident #2. Resident #1 assessed and found with no visible injury related to the incident. Note reflected there is a 2X1 (unit of measure not noted) slightly reddened area noted to the left side of residents left eye. Resident stated that Resident #2 hit him in the face and he hit Resident #2 with his cane on the top of Resident #2's head. Resident #1 stated that the reddened area did not hurt and he wasn't sure if that was related to the incident.</p> <p>Review of Resident #1's progress note dated 10/10/24 reflected social worker followed up with Resident #1 and discussed his feelings. Request for placement was made to various nursing facilities, but placement for Resident #1 was declined by facilities due to Resident #1's aggressive behavior. He was accepted to a group home.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's initial assessment visit on 04/03/24 with PMHNP reflected Resident #1 admitted to mental health conditions, depression and stated someone had insulted him three times (resident not identified). Anxiety: Patient endorsed current symptoms of excessive worry and denies symptoms of restlessness, irritability/agitation, impaired concentration, panic attacks and anticipatory worry/impending doom. Severity level is 2 (Minimal).</p> <p>Review of Resident #1's visit on 05/15/24 with PMHNP reflected Resident admitted to being mad. He stated I was assaulted 4xs [by Resident #2] and, they are still bringing him [Resident #2] around me and right now I'm after him [Resident #2]. Resident #1 stated if he's not around [Resident #2] I'm happy.</p> <p>Review of Resident #1's visit on 05/20/24 with PMHNP reflected Resident #1, Admits to being agitated due to feeling he has been disrespected by another resident [Resident #2]. Received call from facility the past weekend due to resident going outside and refusing to come back in due to not wanting to be around resident [Resident #2] he feels he was disrespected by.</p> <p>Review of Resident #1's visit on 07/31/24 with PMHNP reflected, staff reports resident made a [shank] out of foil and is carrying a cane as a weapon. Patient endorses current symptoms of excessive worry, irritability/agitation and impaired concentration and admits to anxiety and agitation due to, wanting a cane.</p> <p>Review of Resident #1's visit on 08/13/24 with PMHNP reflected, staff reports that patient had an incident where he left the facility and went to a park to look for a stick.</p> <p>Review of Resident #1's visit on 08/25/24 with PMHNP reflected Resident #1 stated he did well as long as another resident [Resident #2] that he has had incidents with stayed away from him and, Resident #1, Becomes agitated when he sees the resident [Resident #2] that he has problems with.</p> <p>Review of Resident #1's visit on 10/06/24 with PMHNP reflected reason for referral anger, physical aggression.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's visit on 10/09/24 with PMHNP reflected reason for referral, Anger, physical aggression. Patient seen today for a new problem. At staff request for continued unstable symptoms that have showed limited improvement. PMHNP visit reflected Resident #1 was seen for a follow up visit due to behaviors that lead to an altercation with another resident [Resident #2]. When asked about the altercation he stated that it was the sixth time he has [Resident #2] hit me or kicked me, in the past he, brought blood on me. I was going to the smoke area, and he was in the way, and I pulled Resident #2's chair and told him he was not supposed to go out there. I was tired of going and getting someone, so I held him back this time and told him you are not going out there you are not supposed to be out there. They want me to get someone every time he goes out there, he said I was here first and that is when he hit me and I hit him back. He thinks he can hit people and cuss them with no recourse. The visit reflected that the PMHNP asked him when you see Resident #2 does that make you angry and Resident #1 responded, yes because every time he comes around I have to watch him. A few days ago he kicked at me, but I didn't notify anyone. He is constantly shooting the finger and cussing me. When asked if he was aware that the resident went to the emergency room with a head injury Resident #2 stated, well, he hit me first and between me and you I am tired and fed up with him so I hit him. Resident #1 said he was anxious when he was around Resident #2 and the facility staff knew he [Resident #2] was mean and cruel, vial and violent. Resident #2 expected everyone to move out of his way and kept getting by with it and, that is the reason he keeps doing it. It's on my mind and I can't forget what hes done to me. I can't stand to be around him. We used to get along he was banned from the smoking area in the past I tried to get him and help him and he still hit me and I don't want to be around him period.</p> <p>Review of Resident #1's visit on 10/01/24 with MSW, LCSW reflected service provided, new referral, reason for referral anger, physical aggression. Patient [Resident #1] described an altercation between him and another resident [Resident #2].</p> <p>Review of Resident #1's visit on 10/08/24 with MSW, LCSW reflected current risk factors, Aggressive Behavior: Current and History,</p> <p>Mental Status Examination Affect: Angry, Anxious, Agitated.</p> <p>Review of Resident #2's face sheet, dated 10/11/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type (which features bouts of mania and sometimes depression), and diffuse trauma brain injury (occurs when the brain is injured by blunt force, causing the brain's nerve fibers to shear of tear).</p> <p>Review of Resident #2's quarterly MDS assessment, dated 08/27/24, reflected a BIMS score of 14 indicating intact cognition. No information was provided in section E regarding potential indicators of Psychosis. No information was provided in section E regarding Resident #1's behaviors, physical or verbal, directed at others or other behavioral symptoms not directed toward others (e.g., hitting or scratching self).</p> <p>On 10/10/24 at 4:18 pm observed Resident #2 in a wheelchair. No wheelchair was listed in his MDS.</p> <p>Review of Resident #2's quarterly care plan reflected:</p> <p>Focus:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Resident #2 had behavior problems as a result of schizoaffective disorder - yelling, racial slurs, name calling</p> <p>2. 09/04/24 aggressive behaviors date initiated 12/15/23 revision on 09/05/24</p> <p>Goals:</p> <p>1. Resident #2 will have less than daily behaviors hitting self. Impulsiveness, racial slurs by review date</p> <p>Date initiated 12/15/23, revision date 03/04/24, and target date 12/09/24</p> <p>Interventions:</p> <p>1. administer medication as ordered, monitor/document for side effects and effectiveness date initiated 12/15/23</p> <p>2. anticipate and meet the resident's needs dated initiated 12/15/23</p> <p>3. Behavior plan in place:</p> <p>1. Resident #2 will smoke in separate smoking area from Resident #1 and will be provided supervision on that break</p> <p>Resident #1 will avoid contact with Resident #2 and if they meet in person, Resident #1 will not say provoking things to Resident #2 or have physical altercation. Resident will alert staff if he feels unsafe or if he feels unsafe or if Resident #2 threatens him for immediate interventions date initiated 09/23/24</p> <p>2. document any behaviors and interventions in clinical record as they occur date initiated 01/26/24</p> <p>3. medication review by psych date initiated 02/15/24</p> <p>4. monitor behavior episodes and attempt to determine underlying causes, consider location, time of day, persons involved, and situation and document behavior and potential causes date initiated 12/15/23</p> <p>5. Weekly discussion regarding social services date initiated 01/26/24</p> <p>Review of Resident #2's progress note dated 09/04/24 6:23 PM reflected ambulance arrived at the facility and stated that they were called by resident #2. The nurse asked the resident why he called and Resident #2 stated he got into an altercation with Resident #1 in the smoking area and his right knee hurt. Assessment of knee revealed no wound, no bleeding or inflammation noted to the knee. Resident #2 insisted on being sent out and stated, if you don't let me go I'll cause hell to everyone here. The responsible party, ADON, DON, medical director, and Administrator were informed. Note reflected, will continue plan of care.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Focused Care of Waxahachie		STREET ADDRESS, CITY, STATE, ZIP CODE  1413 W Main St Waxahachie, TX 75165	
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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's progress note dated 09/04/24 7:36 PM reflected police officer arrived at the facility and insisted on speaking to Resident #1 because of a report an altercation between him and Resident #2. Resident #2 called the police. There were no staff present when the altercation occurred.</p> <p>Review of Resident #2's progress note dated 09/11/24 reflected Resident #2 continued 1 on 1 monitoring (reason for 1 on 1 monitoring not explained in note).</p> <p>Review of Resident #2's progress note dated 09/23/24 6:00 PM reflected resident seen for follow up virtual visit with PMHNP, Resident #2 was placed 1 on 1 due to having multiple on/off behaviors of aggression/agitation with other residents. Medication had been adjusted over the last two weeks. He currently denies being a harm to himself or others. Staff reports that he has not had any noted agitation/aggression with him during one-to-one period and he denied harm to himself or others. Will discontinue 1 on 1 at this time and follow up with resident with face-to-face visit within one week.</p> <p>Review of Resident #2's progress note dated 09/23/24 8:00 PM reflected nurse spoke with resident regarding issues he was having with Resident #1. Resident #2 stated that he felt safe at this time and will do his best to stay away from Resident #1, the resident with whom he was having trouble with. The nurse spoke with the PMHNP regarding the safety of Resident #2 and she stated she had completed an assessment of him and the situation and in her opinion Resident #2 was not a danger to himself or others at this time. The facility was to provide a separate smoking areas Resident #1 and Resident #2 and to keep them separated as much as possible. The note reflected a discussion with the PMHNP to initiate a behavioral care plan and contact with the ombudsman for assistance in developing a behavior plan.</p> <p>Review of Resident #2's progress note dated 10/09/24 by LVN A reflected she heard someone yelling and went into the sunroom and noticed Resident #1 sitting behind resident #2. Resident #1 had his cane raised in the air. Resident #2 was leaning over and he had blood dripping from the top of his head. A second nurse (not identified in the note) went to get the DON, Administrator, and called 911. When the LVN A walked into the sunroom Resident #1 said Resident #2 hit him in the face and he hit Resident #2 on his head with his cane. Resident #2 stated Resident #1 called him a son of a bitch and told him not to talk about his mother. Resident #1 stated Resident #2 hit him in the face, and he hit Resident #2 with his cane. The police came and talked to Resident #2.</p> <p>Review of Resident #2's visit on 01/10/24 with PMHNP reflected reason for referral issues with trauma. Mania: Resident #2 endorsed current symptoms of grandiosity and easily distracted. Anxiety: Resident #2 endorsed symptoms of excessive worry, irritability/agitation and anticipatory worry/impeding doom. Cognitive impairment: Resident #2 endorsed current symptoms of forgetfulness, confusion, mood/personality change and difficulties with activities of daily living.</p> <p>Review of Resident #2's visit on 01/24/24 with PMHNP reflected Mania: Resident #2 endorsed current symptoms of grandiosity and easily distracted.</p> <p>Review of Resident #2's visit on 02/06/24 with PMHNP reflected Mania: Resident #2 endorsed current symptoms of grandiosity and easily distracted and hyper-focused behavior.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's visit on 02/28/24 with PMHNP reflected Mania: Resident #2 endorsed current symptoms of grandiosity and easily distracted, impulsive actions and hyper-focused behavior. Resident #2 endorsed symptoms of decreased concentration. MSE mood - anxious, depressed.</p> <p>Review of Resident #2's visit on 03/10/24 with PMHNP reflected Mania: Resident #2 endorsed current symptoms of grandiosity, impulsive actions and hyper-focused behavior, and history of easily distracted. MSE mood - anxious, depressed.</p> <p>Review of Resident #2's visit on 04/03/24 with PMHNP reflected Mania: Resident #2 endorsed current symptoms of grandiosity, easily distracted and impulsive actions. Anxiety: resident #2 endorsed current symptoms of excess worry and irritability/agitation. MSE anxious, depressed, short-term memory mildly impaired.</p> <p>Review of Resident #2's visit on 04/08/24 with PMHNP reflected Mania: Resident #2 endorsed current symptoms of grandiosity, pressured speech/hyper-verbosity and easily distracted. Psychosis: Resident #2 endorsed current symptoms of delusions. He reports that another resident threw a 20oz. Coke at him and he responded by hitting her back. Resident #2 admitted to feeling own and depressed and being anxious. He denied being a harm to himself or anyone else. Resident #2 endorsed current symptoms of sad moods and decreased concentration.</p> <p>Review of Resident #2's visit on 04/24/24 with PMHNP reflected Mania: Resident #2 endorsed current symptoms of grandiosity, pressured speech/hyper-verbosity and easily distracted. Psychosis: Resident #2 endorses current symptoms of delusions.</p> <p>Review of Resident #2's visit on 05/07/24 with PMHNP reflected Resident #2 endorsed current symptoms of decreased concentration. Mania: Resident #2 endorsed current symptoms of grandiosity, pressured speech/hyper-verbosity and easily distracted. Anxiety: Resident #2 endorsed current symptom of impaired concentration. Cognitive Impairment: Resident #2 endorsed current symptoms of mood/personality change. Psychosis: Resident #2 endorsed current symptoms of delusions. MSE: Mood anxious, depressed, short-term memory mildly impaired.</p> <p>Review of Resident #2's visit on 05/20/24 with PMHNP reflected Resident #2 endorsed current symptom of decreased concentration. Manie: Resident #2 endorsed current symptom of grandiosity, pressured speech/hyper-verbosity and easily distracted. Anxiety: Resident #2 endorsed current symptoms of impaired concentration. Cognitive impairment: Resident #2 endorsed current symptom of mood/personality change. Psychosis: Resident #2 endorsed current symptoms of delusions and responding to internal stimuli. MSE: Mood anxious, depressed, short-term memory mildly impaired.</p> <p>Review of Resident #2's visit on 06/02/24 with PMHNP reflected Resident #2 endorsed current symptoms of decreased concentration. Mania: Resident #2 endorsed symptoms of grandiosity and easily distracted. Cognitive impairment: Resident #2 endorsed current symptoms of forgetfulness mood/personality change. Psychosis: Resident #2 endorsed symptoms of delusions. MSE: Mood anxious, depressed, short-term memory mildly impaired.</p> <p>Review of Resident #2's visit on 01/24/24 with MSW, LCSW reflected Resident #2 was referred due to his anger outbursts and inappropriate remarks such as racial slurs. Brief psychiatric rating scale reflected BPRS current ratings:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Disorientation - moderately severe</p> <p>Grandiosity - moderately severe</p> <p>Review of Resident #2's visit on 02/14/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected</p> <p>affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 02/20/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected</p> <p>affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 02/28/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 03/05/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 03/12/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 03/20/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Resident #2 discussed the incident that happened over the weekend and he processed his feeling for anger.</p> <p>Review of Resident #2's visit on 03/25/24 with MSW, LCSW reflected</p> <p>current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 04/02/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, behavior, conduct problems, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 04/23/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, depression, anxiety, and confusion</p> <p>Resident #2 seemed to be having difficulty managing emotions and longed to be discharged and reside with family.</p> <p>Review of Resident #2's visit on 04/30/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 05/08/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, depression, anxiety, and confusion</p> <p>Review of Resident #2's visit on 05/14/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Disorientation - moderately severe</p> <p>Symptoms Present - anger, depression, anxiety, and confusion</p> <p>Resident #2 discussed the incident he had with, another staff. He processed his feelings of anger. Resident #2 noted how he could have handled things, differently. He listed triggers that made him angry.</p> <p>Review of Resident #2's visit on 05/21/24 with MSW, LCSW reflected history of current illness: Resident #2 was referred due to his anger outbursts and inappropriate remarks, such as racial slurs. Grandiosity moderately severe no change, hostility moderate - increase, and excitement - increase.</p> <p>Review of Resident #2's visit on 05/28/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Review of Resident #2's visit on 06/06/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>Resident #2 reported feelings of anger when speaking about the incident that happened.</p> <p>Review of Resident #2's visit on 06/12/24 with MSW, LCSW reflected current and a history of aggressive behavior. MSE reflected affect (immediate emotional expression) - sad, anxious</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>mood - depressed, elevated (an abnormal heightened emotional stat, such as euphoria or extreme happiness)</p> <p>Grandiosity - moderately severe</p> <p>On 10/11/24 at 12:30 observed Resident #1 ambulating using a wheelchair and had a cane with him.</p> <p>On 10/11/24 at 4:18 pm observed Resident #2 in a wheelchair.</p> <p>Interview on 10/11/24 at 1:04 pm with CNA B revealed as far as she knew, Resident #1 and Resident #2 did not get along. Resident #2 called Resident #1 white trailer trash and Resident #1 did not let that go. CNA B said she observed Resident #1 and Resident #2 argue and they were separated. Resident #1 was on 1 on 1 because of an altercation with Resident #2. CNA B said when Resident #1 saw Resident #2, Resident #1 was on the defense. Staff were all supposed to keep on eye on Resident #1 and Resident #2. Sometimes Resident #2 would come into the group smoking area and Resident #1 would get upset and tell Resident #2 he could not be in that smoking area. CNA B said because of Resident #2's brain injury, she was not sure if he understood he could not be in the community smoking area. CNA B said Resident #2 did not verbalize that he knew that he was not supposed to be in the community smoking area, and he did not do one half of the stuff he was told.</p> <p>Intervi [TRUNCATED]</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</b></p> <p>Based on record review and interview, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one (Resident #1) of three residents reviewed for transfer and discharge rights, in that:</p> <p>The facility failed to provide documentation that Resident #1 received sufficient preparation and orientation when he was discharged to a group home to ensure a safe discharge. Resident #1 was discharged from the facility on 10/11/24.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs upon discharge.</p> <p>Findings Included:</p> <p>Review of Resident #1's face sheet, dated 10/11/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included diffuse traumatic brain injury (occurs when the brain is injured by blunt force, causing the brain's nerve fibers to shear or tear), depression and heart failure. Resident #1 is listed as his own responsible party.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 08/27/24, reflected a BIMS score of 15 indicating intact cognition. Neither device was listed in his MDS. No information was provided in section E regarding Resident #1's behavior and did not include information about physical or verbal behaviors directed at others.</p> <p>On 10/11/24 at 12:30 observed Resident #1 ambulated using a wheelchair and he had a cane with him.</p> <p>Review of Resident #1's quarterly care plan reflected:</p> <p>Focus and revision dated 09/20/23 Discharge has been determined to not be feasible based on Resident #1's inability to ambulate and care for self at home. Resident physician, resident representative agree on long-term care placement</p> <p>Goal - Resident and Resident Representative will express satisfaction with community through next review date, date initiated and date revision 09/10/24 target dated 12/03/24.</p> <p>Interventions - discuss placement goals for staying in community and refine and redefine and adjust as needed date initiated 09/20/23, encourage resident to verbalize fears and concerns and clarify any misconceptions he/she may have regarding not being able to meet previous discharge goals and continuing to stay at community date initiated 09/20/23, resident and or responsible party will define expectations for community care, date initiated 09/20/24.</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress note date 10/11/24 reflected social worker followed up with Resident #1 discussed his feelings, respecting individuals and placement. Resident #1 was not very receptive due to him being angry and upset but became cooperative and verbalized understanding later. Resident #1 refused and was not open to receiving treatment/counseling from inpatient hospital. Social worker emailed/faxed Resident #1's clinicals to various nursing facilities and was informed that he was declined due to aggressive behavior. Clinicals were sent to three skilled nursing facilities who declined admission and a fourth facility that was awaiting. Clinicals were faxed to a group home and Resident #1 was accepted. Resident #1's needs will be met at the group home and is schedule to leave on 10/11/24 at 8:00 am.</p> <p>Review of Resident #1's progress note dated 10/11/24 reflected Resident #1 was discharged to a group living home to evaluate and treat for skilled nursing, physical therapy and occupational therapy. Facility driver transported Resident #1 with all his belongings and medications. Resident was cooperative.</p> <p>Review of Resident #1's progress note LATE ENTRY (neither the date or the time of this entry was indicated) placed call and spoke with ombudsman regarding situation with incident involving the resident. Explained to ombudsman the initial discharge for resident to a safe environment for the safety of the other resident. Follow up from facility to follow.</p> <p>Review of Resident #1's order, by the Medical Director, date 10/13/24 stated discharge patient [Resident #1].</p> <p>Interview on 10/11/24 at 5:32 p.m., with the ombudsman revealed she was not aware of Resident #1's discharge. She said she knew about Resident #1's incident with Resident #2 on 10/09/24 but did not know about the discharge and had not had a conversation with facility about Resident #1 being discharged . She said the facility knew they had to tell her about a discharge, she did not receive a discharge letter. She revealed she did not have any time to address anything involving the discharge. She stated that the discharge would fall under a 7-day discharge and the resident or the family member needed time in case they wanted to appeal.</p> <p>Interview on 10/13/24 at 4:04 p.m., with the facility Medical Director revealed he spoke with the facility DON and approved Resident #1's discharge from the facility on 10/11/24 and did not have a problem with the discharge. The medical director understood that Resident #1 was the instigator in many circumstances involving another resident and he had no problem with the discharge, but he did not enter the order in the record until 10/13/24.</p> <p>Review of facility discharge policy included long-term care ombudsman program policies and procedures:</p> <p>Notice of discharge from a Medicaid certified nursing facility introduction: the facility must ensure that transfer or discharge is documents in the resident's medical record and the information must be communicated to the receiving provider. If the facility is citing needs cannot be met as a reason for discharge, documentation must include the facilities attempts to meet these needs and the services available at the receiving facility to meet these needs.</p> <p>The written discharge notice must include:</p> <p>(continued on next page)</p>		

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  10/18/2024
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.

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the reason for the transfer or discharge</p> <p>a statement of the resident's appeal rights, including</p> <ul style="list-style-type: none"> <li>o the resident has the right to appeal the action as outlined in HHSC's Fair Fraud Hearings handbook within 90 days after the date of the notice</li> <li>o information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request</li> <li>o the name, address, email address, and telephone number of the managing local ombudsman and the toll-free number of the managing local ombudsman program</li> </ul> <p>Review of facility eMAR discharge instruction date 10/11/24 reflected:</p> <p>the name of the person Resident #2 is discharging from the facility with (Resident #1 was discharged from the facility via facility van with a facility transportation driver).</p> <p>The primary physicians name and telephone number (the facility medical director's name and telephone number)</p> <p>Pharmacy name and telephone number</p> <p>In home care or services listed the name of the group home and the telephone where Resident #1 was being discharge to</p> <p>No medical equipment arrangement (Resident #1 was in his wheelchair and holding his cane)</p> <p>Housing arrangements stated group home</p> <p>Medical Education contained comments only - medication list and instructions attached provide by nurse</p> <p>Prevention and disease management education listed verbal and written by not dopic of education provided</p> <p>Summary of Resident #1's stay reflected [Resident #1] was admitted into the facility at receive nursing care 7/24</p> <p>Describe any treatments to continue after discharge reflected [Resident #1] will continue treatment in a group home</p> <p>Current ambulation/locomotion support: uses wheelchair</p> <p>Current eating support: independent</p> <p>Current toileting support: needs supervision</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Current dressing support: needs supervision</p> <p>Scheduled appointments and tests appointment Primary Care Physician wellness/health on 10/14/24</p> <p>Signed by LVN and LVSW, MA</p> <p>Discharge Instructions revealed I am signing these discharge instructions have been reviewed with me in a language I understand, and my questions have been answered Signed by Resident #1</p> <p>Disposition of valuables - belongings in Resident #1's possession</p> <p>Medications reconciled with Resident/Representative Party - No</p> <p>Review of Facility Transfer or Discharge, Preparing a Resident for:</p> <p>Residents will be prepared in advance for discharge. Policy interpretation and implementation:</p> <ol style="list-style-type: none"> <li>1. When a resident is schedule for transfer or discharge, the business office will notify services of the transfer or discharge so that appropriate procedure can be implemented.</li> <li>2. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four hours before the resident's discharge or transfer from the facility.</li> <li>3. Nursing services is responsible for:               <ol style="list-style-type: none"> <li>a. obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment</li> <li>b. preparing the discharge summary and post-discharge planforwarding charge slips to the business office</li> <li>c. Providing the resident or representative with required documents (i.e. discharge summary and plan)</li> <li>d. Completing discharge note in the medical record</li> <li>e. Forwarding charge slips to the business office</li> <li>f. Directing the resident or representative to the business office prior to the transfer or discharge</li> <li>g. Forwarding completed records to the business office</li> <li>h. The business office is responsible for:                   <ol style="list-style-type: none"> <li>a. Informing appropriate departments of the resident's transfer or discharge</li> </ol> </li> </ol> </li> </ol> <p>(continued on next page)</p>

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