STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455591	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Waxahachie	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 2 of 7 residents (Residents #1 & #2) reviewed for resident rights in that: The facility failed to ensure Residents #1 and #2 call lights was within reach on 10/29/24. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #1's admission record dated 10/29/24 documented a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included: sepsis (serious condition in which the body responds improperly to an infection), major depressive disorder (persistent low mood and loss of interest in activities that people enjoy), muscle weakness (lack of muscle strength), and gastro esophageal reflux disease without esophagitis (a digestive disorder that occurs when stomach acid flows back into the esophagus without causing inflammation of the esophagus). Record review of Resident #1's Quarterly MDS assessment, dated 09/22/24, revealed the resident had a BIMS score of 00 indicating the resident had severe cognitive impairment. The MDS also revealed Resident #1 was dependent in various areas of activities of daily living such as eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower dressing, and personal hygiene. Record review of Resident #1's care plan, dated 10/29/24, revealed Resident #1 was care planned for falls and had an intervention of: ensure call light is in reach and answer promptly. No interview could be conducted with Resident #1 due to the resident not being interview able. Observation on 10/29/24 at 9:24 a.m., revealed Resident #1's call light was tied to his nightstand and out of his reach. Observation on 10/29/24 at 11:24 a.m., revealed Resident #1's call light was tied to his nightstand and out of his reach. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/29/24 at 12:20 p.m., revealed Resident #1's call light was tied to his nightstand and out of his reach. Observation on 10/29/24 at 1:49 p.m., revealed Resident #1's call light was tied to his nightstand and out of his reach. Record review of Resident #2's admission record dated 10/24/24 documented an [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included: cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it) essential primary hypertension (abnormally high blood pressure that not caused by a medical condition), and gastro esophageal reflux disease without esophagitis (a digestive disorder that occurs when stomach acid flows back into the esophagus without causing inflammation of the esophagus). Record review of Resident #2's Quarterly MDS assessment, dated 08/20/24, revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. The MDS also revealed Resident #2 was dependent in various areas of activities of daily living such as eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower dressing, putting on/taking of footwear, and personal hygiene. Record review of Resident #2's care plan, dated 10/29/24, revealed Resident #2 was care planned for falls and had an intervention of: ensure call light is in reach and answer promptly. During an interview with Resident #2 on 10/29/24 at 1:49 p.m., Resident #2 stated that his call light clip has been broken for a while so staff put his call light on his nightstand. Resident #2 stated if he needed assistance, he would wait on staff to make rounds or yell for help. Observation on 10/29/24 at 12:20 p.m., revealed Resident #1's call light was laid on top of his nightstand and out of his reach. Observation on 10/29/24 at 1:49 p.m., revealed Resident #1's call light was laid on top of his nightstand and out of his reach. During an interview on 10/29/24 at 1:00 p.m., CNA A stated that CNAs should make rounds at least every two hours. CNA A stated that CNAs should be looking to see if a resident needs assistance, ensuring call lights were within reach, and making sure all residents were comfortable. CNA A stated if a resident call light was not within reach, then they resident could fall attempting to reach it or the resident would not receive assistance. During an interview on 10/29/24 at 4:10 p.m., the DON stated that anyone that entered the resident's room was responsible for ensuring the call light was within reach. The DON stated that CNAs frequently make rounds so they would be most likely to notice if a call light was not within reach. The DON stated if a call light was out of reach, then they resident would not be able to call for assistance if they needed. (continued on next page)

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 10/29/2024
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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24 at 4:00 p.m., the ADM stated a call light is a communication medium between residents and staff. The ADM stated if a call light was not within reach, then a resident would not be able to call for help if needed. The ADM stated it's everyone responsibility to ensure the call lights are within reach. The ADM stated his expectations are for all call lights to be within reach. Review of the facility's Answering the Call Light policy, revised September 2022, reflected, Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines 1. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. 2. Ask the resident to return the demonstration. 3. Explain to the resident that a call system is also located in his/her bathroom. 4. Be sure that the call light is pulled in and functioning at all times. 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and form the floor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 7 residents (Resident #3) reviewed for a clean and homelike environment. The facility failed to ensure Resident #3's urinal was emptied appropriately on 10/29/24. This failure placed residents at risk of decreased feelings of self-worth and a diminished quality of life. Findings included: A record review of Resident #3's face sheet dated 10/29/24 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3's diagnoses included osteomyelitis (serious bone infection that causes inflammation and swelling in the bone), Unspecified dementia (loss of cognitive functioning to the extent that it interferes with a person's daily life and activities), major depressive disorder (persistent low mood and loss of interest in activities that people enjoy), Type 2 diabetes mellitus with foot ulcer (open sore that can develop on the foot of someone with diabetes) and muscle weakness (loss of muscle strength). A record review of Resident #3's Annual MDS assessment, dated 10/21/24, reflected Resident #3 had a BIMS score of 11, which indicated moderately impaired. Resident #3's Annual MDS Section GG Functional Abilities and Goals reflected that Resident #3 required dependent assistance in the area of toileting hygiene, shower/bathe self, and personal hygiene. A record review of Resident #3's care plan, dated 09/04/24, reflected Resident #3 was care planned for: the resident has mixed bladder incontinence and is at risk for skin breakdown r/t incont of urine r/t activity intolerance, confusion, dementia, impaired mobility, physical limitations, ADL self-care performance deficit r/t disease processes, hemiplegia, dementia, and weakness, and resident has Alzheimer's with fluctuation between stages. During an observation on 10/29/24 at 9:24 a.m., Resident #3's urinal had a yellowish liquid in it that appeared to be urine. During an observation on 10/29/24 at 3:16 p.m., Resident #3's urinal had a yellowish liquid in it that appeared to be urine. During an interview on 10/29/24 at 3:16 p.m., Resident #3 stated that the urinal has had urine in it since around 8:45 a.m. Resident #3 stated his urinal always has urine in it. Resident #3 stated that there are only a few staff the empty his urinal like they are supposed to. (continued on next page)

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Focused Care of Waxahachie	1413 W Main St Waxahachie, TX 75165

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24 at 1:00 p.m., CNA A stated that CNAs should make rounds at least every two hours. CNA A stated that CNAs should be looking to see if a resident needs assistance, ensuring call lights were within reach, and making sure all residents were comfortable. CNA A stated that it's anyone's responsibility that walked into the resident's room to ensure that the urinal was emptied appropriately. CNA A stated urinal should be emptied once a resident is finished urinating unless told otherwise. CNA A stated if a urinal is not emptied that could cause the room to have bad odor. During an interview on 10/29/24 at 4:10 p.m., the DON stated that a resident's urinal should be emptied as care is provided. The DON stated that direct care staff (CNAs and Nurses) are responsible for emptying a resident urinal. The DON stated that if a urinal was not emptied in a timely manner the urinal could spill or the resident's room could have an odor from the urine in the urinal. During an interview on 10/29/24 at 4:00 p.m., the ADM stated that urinal should be emptied during patient care. The ADM stated if the urinal was not emptied then that could cause an infection control issues or flies. The ADM stated it's the assigned nursing staff responsibility to ensure urinal are emptied appropriately. Review of the facility's Resident Rights policy, revised December 2021, reflected, Policy statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility, these rights include the resident's right to: A. A dignified existence; B. Be treated with respect, kindness, and dignity; C. Be free from abuse, neglect, misappropriation of property, and exploitation; D. Be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms; E. Self-Determination; .