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	07/01/2025

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 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. (continued on next page)

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

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

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, clean, comfortable, and homelike environment for 1 (Resident #1) of 5 residents reviewed for environment. The facility failed to ensure Resident #1 was provided clean bed linens that were in good condition. This failure placed residents at risk of living in an uncomfortable environment leading to a diminished quality of life. Findings included: Record review of Resident #1's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Diabetes Mellitus with Diabetic Nephropathy (elevated blood sugar that has caused kidney damage) and constipation. Record review of Resident #1's Baseline Care Plan, dated 06/17/2025, reflected Resident #1 was dependent for transferring from chair to bed and bed to chair, toileting hygiene, showering and bathing, and lower and upper body dressing. The care plan reflected Resident #1 was always incontinent of bowel and bladder and used a wheelchair for mobility. Record review of Resident #1's admission MDS assessment dated [DATE], reflected the resident had a BIMS score of 14, which indicated she was cognitively intact. In an interview and observation on 07/01/2025 at 12:00 PM Resident #1was lying in bed, her hair was unbrushed, and her clothing had food crumbs on it. Her sheets had a urine odor. She stated she was not ok. She stated she had not been showered in 8 days. She stated she had asked to get up but was told she must stay in the bed today. She pointed to her sheets at a basketball size brown dried stained ring on her Resident #1 sheets. She then pulled her sheet back and rolled to the side revealing 2 (two) additional large brown rings under her padding that was placed on the bed between her body and the bottom fitted sheet. She stated not being clean made her feel dirty and trashy. In an interview on 07/01/2025 at 12:10 PM CNA A stated she had been a certified nurse aide since January 2025, but this was her fourth day at this facility. She stated she received 2 days of orientation in the facility. She stated she had not worked with Resident #1 prior to today. She stated she had received a verbal report from the nurse this morning on residents needs and was told to not get Resident #1 up out of bed. She stated she did not realize Resident #1's bottom bed sheets were stained. She stated the CNAs were responsible for changing residents' sheets. She stated having dirty sheets would make the residents feel dirty. In an interview on 07/01/2025 at 12:15 PM CNA B stated she was responsible for resident transfers to and from appointments but was assisting on the floor today. She stated there were 2 staff members that did call in today, so the staff were all working together to meet the needs of the residents. She stated she was not aware Resident #1 had brown stained sheets. CNA B stated the CNAs were responsible for changing residents' sheets. She stated she was heading to assist the other CNA A to help clean Resident #1 up now. She stated not having clean sheets could impact a resident negatively. She stated it could bother the resident and make them uncomfortable and feel dirty. In an interview on 07/01/2025 at 1:45 PM LVN C stated she had worked at the facility for 2 years. She stated Resident #1 was a new admit to the facility. She stated she did tell CNA A that Resident #1 did not get up for breakfast. She stated the aide must have misunderstood her and left Resident #1 in bed. LVN C stated if Resident #1 asked to get up then the staff should get her up. LVN C stated the CNAs were responsible for changing residents' sheets. She stated sheets were to be changed on shower days and as needed if soiled. She stated no residents should be left in dirty sheets. She stated leaving a resident in dirty sheets and not showered could impact their dignity making a resident depressed. In an interview on 07/01/2025 at 2:30pm The Director of Clinical Operation stated she expected residents' bed sheets were changed on shower days and as needed. She stated the facility practice was to throw away stained or worn sheets in the trash to ensure they were not used on residents' beds. She stated leaving a resident in soiled or dirty sheets, physically it can cause skin breakdown, emotionally it can make them feel unclean. Record review of the undated facility's policy titled Quality of Life Homelike Environment reflected Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall Maximize, to the extent possible. the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include Clean, sanitary, and orderly environment and clean bed and bath linens that are in good condition.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 1 of 5 residents (Resident #1) reviewed for ADLs. The facility failed to ensure Resident #1 received showers on 06/18/2025, 06/23/2025, 06/27/2025, and 06/30/2025. This failure could place residents at risk of not being provided care and assistance when needed. Findings Included: Record review of Resident #1's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Diabetes Mellitus with Diabetic Nephropathy (elevated blood sugar that has caused kidney damage) and constipation. Record review of Resident #1's Baseline Care Plan, dated 06/17/2025, reflected Resident #1 was dependent for transferring from chair to bed and bed to chair, toileting hygiene, showering, bathing, lower and upper body dressing. The care plan reflected Resident #1 was always incontinent of bowel and bladder and used a wheelchair for mobility. Record review of Resident #1's admission MDS assessment dated [DATE], reflected the resident had a BIMS score of 14, which indicated she was cognitively intact. Record review of Resident #1 Documentation Survey Report V2 (a report reflecting care provided to the resident) reflected Resident #1 was assigned to receive her shower every Monday, Wednesday, and Friday. The report reflected Resident #1 did not receive her showers on 06/18/2025, 06/23/2025, 06/27/2025, and 06/30/2025. There was no documentation of Resident #1 refusing her showers. Record review of Resident #1's Progress Notes dated 06/17/2025 through 07/01/2025 reflected there was no documentation of Resident #1 refusing care. In an interview and observation on 07/01/2025 at 12:00 PM Resident #1was lying in bed, her hair was unbrushed, and her clothing had food crumbs on it. Her sheets had a urine odor. She stated she was not ok. She stated she had not been showered in 8 days. She stated she had asked to get up but was told she must stay in the bed today. She pointed to her sheets at a basketball size brown dried stained ring on her sheets. She then pulled her sheet back and rolled to the side revealing 2 addition large brown rings under her padding that was placed on the bed between her body and the bottom fitted sheet. She stated not being clean made her feel dirty and trashy. In an interview on 07/01/2025 at 12:10 PM CNA A stated she had been a certified nurse aide since January 2025, but this was her fourth day at this facility. She stated she received 2 days of orientation in the facility. She stated she had received a verbal report from the nurse this morning on residents needs and was told to not get Resident #1 up out of bed. She stated the CNAs were responsible for giving Resident #1 a shower and cleaning her. She stated she was not sure of Resident #1's shower days. She stated not getting showers would make the resident feel dirty. In an interview on 07/01/2025 at 12:15 PM CNA B stated she was responsible for resident transfers to and from appointments but was assisting on the floor today. She stated she was not sure when Resident #1 had her last shower. She stated that the shower schedule was at the nurse's station. She stated she was heading to assist the other CNA to help clean Resident #1 up now. She stated not having been showered could impact a resident negatively. She stated it could bother the resident and make them uncomfortable and feel dirty. In an interview on 07/01/2025 at 1:45 PM LVN C stated she had worked at the facility for 2 years. She stated Resident #1 was a new admit to the facility. She stated her showers were scheduled for 2pm-10pm shift on Monday, Wednesday, and Friday. She stated the aides looked at the shower book to find out who needed showers and what days. She stated she was telling CNA A that Resident #1 did not get up for breakfast. She stated the aide must have misunderstood her and left Resident #1 in bed. She stated if Resident #1 asked to get up then the staff should get her up. She stated residents should get their showers on shower days and as needed. She stated Resident #1 has not refused showers that she was aware of. She stated if a resident were to refuse a shower, then the nurses must follow up and document the refusal. She stated leaving a resident dirty and not showered could impact their dignity making a resident depressed. In an interview on 07/01/2025 at 2:30pm The Director of Clinical Operations stated she expected showers to be completed on a resident's assigned shower days. She stated the nursing assistants were responsible for showers. She stated the certified nursing assistants had access to the Kardex which gives a detailed schedule of residents' needs including shower days and schedule. She stated there was also a schedule for residents' showers at the nurse's station. She stated the nurse aides were instructed on the Kardex and shower schedule upon orientation. She stated she was not aware of Resident #1 refusing any showers. She stated the nurse should have followed up with any shower refusal. She stated not bathing