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	12/09/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 interview and record review, the facility failed to immediately notify the residents' representative of the changes in the resident's physical and mental health for one (Resident #1) of seven residents reviewed for notification of changes. The facility failed to ensure Resident #1's RP was notified when he was found with ants on him while lying in bed on 10/22/2025. This failure placed residents at risk of a decreased quality of life and risk of not having their responsible party represent them in medical and care decisions.Findings included: Record review of Resident #1's face sheet dated 10/24/2025 revealed a 65-yer-old man with an initial admission date of 6/10/2022 and a recent admission date of 3/27/2025 with diagnoses that included hemiplegia and hemiparesis (paralysis and weakness on one side of the body), Chronic Obstructive Pulmonary Disease (COPD - group of breathing disorders), Type 2 diabetes (blood sugar disorder) sepsis (infection throughout the body) and dementia (memory disorder). Review also revealed Resident #1's RP and POA was listed as his FM. Review of Resident #1's quarterly MDS dated [DATE], reflected a BIMS score of 10, suggesting moderate cognitive impairment. Review of Resident #1's care plan reflected the focus: The resident has a terminal prognosis and is under hospice services with [hospice company] since 05/19/25 with the goal of The resident's comfort will be maintained through the review date and an intervention Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #1's progress notes dated 10/24/2025 at 11:57 am, reflected no progress notes on 10/22/2025 regarding resident being found with ants on his body or that Resident #1's RP was contacted. During an interview on 10/24/2025 at 1:06 pm, LVN A stated she was making rounds around 6:30 in the morning on 10/22/2025 and noticed ants on Resident #1. She stated she noticed two ants crawling on Resident #1: one on his forehead and one on his throat. She stated the ant on his throat was consuming food on his neck area and the other ant was just crawling across his forehead. She stated Resident #1 often ate at night and he had food all over his gown and bed. She stated she did not notice ants on the floor, resident's bed or anywhere else on Resident #1. She stated she did a quick assessment of Resident #1, and no bites were noted. She stated she told the DON about it, and he said he would handle it, so she had not documented anything or called Residents #1's RP to notify her. She stated if RPs were not notified, then they might not know what is going on with the resident.During an interview on 10/24/2025 at 1:14 pm, HN stated she found out about the ants on Resident #1 on 10/23/2025 when she had come to the facility for his normal visit. She stated she came to visit resident on Mondays and Thursdays. She stated she had not notified the RP, because no one had notified her until the next day when she had come to the facility. She stated she had assessed the resident and had not noticed any insect bites on him in the area where the staff had told her they found the ants. During an interview on 10/24/2025 at 1:32 pm, the ADM stated he was aware ants had been found in Resident #1's room as it was discussed in the morning meeting on 10/23/2025. He stated the room had been cleaned and treated and they had a regular pest control program. He stated he was not aware until today that Resident #1 had ants on him, he was told there were ants in the room by the wall. He stated his expectation is that staff would have assessed resident for any injury, documented in the EMR and notified the RP. During an interview on 10/24/2025 at 1:49 pm, the DON stated he was aware of the ants being found on Resident #1 on 10/22/2025. He stated he had told LVN A she could go back to work, as she was passing medications that morning and he would take care of it. He stated he had done a complete head to toe assessment of the resident for any injury or skin issues, and none were found. He stated he did not document his assessment of Resident #1 in the EMR and had not called the RP or hospice. He stated he believed the hospice CNAs were verbally informed of the ants when they came to provide care for Resident #1 in the morning on 10/22/2025. During an interview on 10/24/2025 at 2:50 pm, FM stated she was not aware Resident #1 had been found with ants on him while lying in bed. FM stated the facility is usually pretty good about letting her know what's going on with Resident #1, so it bothered her that no one called her. She stated Resident #1 was partially paralyzed and doesn't always feel everything so having ants on him could have been a problem - if they bit him, he may not have even noticed it. Review of Pest Control logbook on 10/24/2025 reflected an entry on 10/22/2025 noting ants were found around Resident #1's bed, it was reported by LVN A and pest control was coming 10/24/2025.A facility policy on Resident Rights was requested on 10/24/2025 via email at 10:45 am but was never received.

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services which includes the accurate acquiring, receiving, dispensing and administering of medications to meet the needs for one resident (Resident #1) of 6 residents reviewed for pharmacy services, in that: 1) The facility failed to administer medications correctly on 10/3/2025 at 6:00 am.2) The facility failed to administer medications correctly on 10/3/2025 at 4:00 pm.3) The facility failed to administer medications correctly on 10/5/2025 at 8:00 am This failure placed residents at risk for medical errors, complications, decreased quality of life and hospitalization. Findings included:Review of Resident #1's face sheet dated 10/16/2025 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: type 2 diabetes (blood sugar disorder), hyperlipidemia (high cholesterol), chronic obstructive pulmonary disease (breathing disorder), hypertension (high blood pressure), seizures (temporary episode of abnormal electrical activity in the brain) and cerebral infarction (blood flow to the brain is blocked or interrupted). Review of Resident #1's MDS assessment dated [DATE], type 99 = none of the above, reflected no entry for BIMS score, but an entry under staff assessment for mental status as 0, indicating Memory OK and an entry of 1, indicating Modified independence - some difficulty in new situations only for Cognitive Skills for Daily Decision Making Review of Resident #1's orders reflected orders dated 10/3/2025:lamotrigine Oral Tablet 25 MG (Lamotrigine) Give 2 tablet by mouth two times a day for seizure [sic].Pregabalin Oral Capsule 200 MG (Pregabalin) Give 1 capsule by mouth three times a day for neuropathy] (nerve damage that can cause numbness, tingling, and pain). Review of Resident #1's progress notes on 10/16/2025 reflected no entries on 10/3/2025 or 10/5/2025 concerning medication errors or issues. Review of Resident #1's pain assessment dated [DATE] on dayshift reflected LVN C noted her pain to be 0. Review of Resident #1's vital signs assessment dated [DATE] on dayshift reflected her vital signs had been charted by LVN C and were all within normal limits. Review of Resident #1's October 2025 MAR on 10/16/2025 reflected that:The Lamotrigine medication administration was signed off on 10/3/2025 for the 6:00 am dose by LVN A.The Lamotrigine medication administration was signed off on 10/3/2025 for the 4:00 pm dose by LVN B.The Pregabalin medication administration was signed off on 10/5/2025 for the 8:00 am dose by LVN C. Review of Resident #1's Controlled Drug Administration Record (CDAR) dated 10/3/2025 reflected that:One tablet of Lamotrigine was given on 10/3/2025 at 5:58 am by LVN AOne tablet of Lamotrigine was given on 10/3/2025 at 4:45 pm by LVN BNo entry for Pregabalin administration on 10/5/2025 at 8:00 am. During an interview on 10/16/2025 at 11:17 am, FM stated Resident #1 was admitted to the facility on [DATE] for a respite stay (temporary period of care for an individual, giving the primary care giver a break).] They stated they gave the medication bottles to the nurse and the pill counts were on the label of each medication bottle. FM stated the nurse had not counted the medications with them or provided them with a sign off sheet on the medications and their counts. FM stated they picked up the medications on 10/8/2025 and the counts looked off on several of the bottles and FM suspected Resident #1 did not get her medications as ordered which concerned them because this was the first time the FM had utilized respite services for Resident #1. During an interview on 10/16/2025 at 3:00 pm the ADM stated he was not aware of the medication errors until this investigator informed him and showed him the count sheets. He stated the med errors should have been reported. He also stated his expectation is that staff will follow orders for medications. During an interview on 10/16/2025 at 3:25 pm, LVN C stated he worked the morning shift on 10/5/2025 and passed medications to Resident #1. He stated if he signed the Pregabalin off in the MAR then I think I gave it. He stated he was not sure why he had signed it off in the MAR and not on the CDAR. He then stated he was not sure if he gave the Pregabalin medication or not. He stated that not giving medications but signing them off would have been a med error and med errors need to be reported to the DON so they can investigate He stated Resident #1 had neuropathy and not getting her Pregabalin medication could have caused the potential for neuropathic pain. LVN C stated he had not recalled Resident #1 complaining of pain. During an interview on 10/16/2025 at 4:25 pm, LVN D stated she relieved LVN A on the morning on 10/4/2025 and LVN A told her she and LVN B had only given one tablet of Lamotrigine, and it should be two. LVN D stated LVN B told her to make sure you give two on this round. LVN D stated she did not report this to anyone because she was just coming on shift, and she assumed LVN A would have let the DON know of the errors. She stated she was aware that med errors needed to be reported immediately to the DON. During an interview on 10/21/2025 at 5:59 pm, LVN A stated she had worked the night shift on

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review, the facility failed to ensure that medical records were accurately documented for one (Resident #1) of eight (8) residents reviewed for accurate clinical records, in that: The facility failed to ensure assessments for Resident #1 were documented in the medical record after he was discovered with ants on him while lying in bed on 10/22/2025. This deficient practice could result in errors in care and treatment and violate resident rights.Findings included: Review of face sheet dated 10/24/2025 revealed a 65-yer-old man with an initial admission date of 6/10/2022 and a recent admission date of 3/27/2025 with diagnoses that included hemiplegia and hemiparesis (paralysis and weakness on one side of the body), Chronic Obstructive Pulmonary Disease (COPD - group of breathing disorders), Type 2 diabetes (blood sugar disorder) sepsis (infection throughout the body) and dementia (memory disorder). Review also revealed Resident #1's RP and POA was listed as his FM.Review of Resident #1's quarterly MDS dated [DATE], reflected a BIMS score of 10, suggesting mild cognitive impairment. Review of Resident #1's care plan reflected the focus: The resident has a terminal prognosis and is under hospice services with [hospice company] since 05/19/25 with the goal of The resident's comfort will be maintained through the review date and an intervention Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Review of progress notes dated 10/24/2025 at 11:57 am, reflected no progress notes on 10/22/2025 regarding resident being found with ants on his body, an assessment being completed or that Resident #1's RP was contacted.During an interview on 10/24/2025 at 1:06 pm, LVN A stated she was making rounds around 6:30 in the morning on 10/22/2025 and noticed ants on Resident #1. She stated she noticed two ants crawling on Resident #1: one on his forehead and one on his throat. She stated the ant on his throat was consuming food deposits on his neck area and the other ant was just crawling across his forehead. She stated Resident #1 often ate at night and he had food deposits all over his gown and bed. She stated she did not notice ants on the floor, resident's bed or anywhere else on Resident #1. She stated she did a quick assessment of Resident #1, and no bites were noted. She stated she told the DON about it, and he said he would handle it, so she had not documented anything in the EMR. During a second interview on 10/24/2025 at 1:14 pm, LVN A stated she did not document her finding of ants or her assessment in the EMR because she was told by the ADON not to document anything in her charting about it. She stated the ADON told her she did not have to make out an incident report because there were no bites and no harm done, so she followed the ADON's instructions. She stated she was conflicted by what to do and as a nurse she is supposed to document in the resident's chart when something happens. During an interview on 10/24/2025 at 1:32 pm, the ADM stated he was aware ants had been found in Resident #1's room as it was discussed in the morning meeting on 10/23/2025. He stated the room had been cleaned and treated and they had a regular pest control program. He stated he was not aware until today that Resident #1 had ants on him, he was told there were ants in the room by the wall. He stated his expectation is that staff would have assessed residents for any injury and documented in the EMR. During an interview on 10/24/2025 at 1:49 pm, the DON stated he was aware of the ants being found on Resident #1 on 10/22/2025. He stated he had told LVN A she could go back to work, as she was passing medications that morning and he would take care of it. He stated he had done a complete head to toe assessment of the resident for any injury or skin issues, and none were found. He stated he had documented his assessment of Resident #1 in the Standards of Care book but did not put anything in the EMR. He stated the Standards of Care book was not part of the resident's medical record. He stated he had reviewed Resident #1's progress notes and had not found any documentation of the assessments done after the ants were found. During an interview on 10/24/2025 at 2:24 pm, the ADON stated LVN A had informed her of the ants being found on Resident #1. She stated, I think [LVN A] might have misunderstood me. She stated she did not mean don't document what happened in the medical record, she meant that an incident report didn't need to be done. She stated she had not documented anything in the EMR on Resident #1 being found with ants on his body. Review of Standards of Care book revealed the following entry under Quarterly Service Intensive Families: [Resident #1], Ants found in room/on resident bed/no bites noted, skin, warm, dry intact, cleaned, placed request for pest control in maintenance log Review of facility policy Charting and Documentation revised July 2017, revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's