

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  03/02/2026
NAME OF PROVIDER OR SUPPLIER  Focused Care of Waxahachie		STREET ADDRESS, CITY, STATE, ZIP CODE  1413 W Main St Waxahachie, TX 75165	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review the facility failed to ensure residents received adequate supervision, to the extent possible for 1 of 8 residents (Resident #1) reviewed for safety. The facility failed to ensure Resident #1 was provided adequate supervision on 02/08/2026 when Resident #1 pushed open a facility exit door, activating both the door alarm and Resident #1's wander guard alarm, and exited the facility traveling approximately 500 ft, crossing a street, and falling (no injuries). The facility was notified by a passerby driving a car of resident's elopement. The noncompliance was identified as Past Noncompliance. The Immediate Jeopardy (IJ) began on 02/08/2026 and ended on 02/09/2026. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for avoidable accidents, injuries, and possible death. Findings included: Record review of Resident #1's face sheet, dated 02/26/2026, revealed a ninety-two-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included major depressive disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and loss of interest in activities lasting at least two weeks), restlessness and agitation, and impulsiveness. Record review of Resident #1's care plan revealed a focus dated 11/25/2025 Resident #1 was an elopement risk/wanderer and was at risk for possible injury related to impaired safety awareness and diagnoses of dementia (a progressive, irreversible syndrome characterized by a decline in memory, thinking, behavior, and daily function due to nerve cell damage) with interventions dated 11/25/2025 distract Resident #1 from wandering by offering pleasant diversions, structured activities, food, conversation, television or books, provide structured activities: toileting, walking inside and outside, reorientation strategies, including signs, pictures and memory boxes and wander guard (a small discreet wearable device), worn as a bracelet to prevent at-risk residents from wandering, bracelet will alert staff if and when resident attempted to exit doors of facility) and staff to monitor daily. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 11/25/2025 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 6 indicating severe cognitive issues and Section E - Behavior Wandering - Presence and Frequency has the resident wandered, revealed behavior not exhibited. Observation on 02/27/2026 at 3:55 PM of facility non-audio video dated 02/08/2026 revealed at 10:58:30 AM Resident #1 was standing directly in front of an exit door with his walker in front of him. No other person observed in the video. Video reflected Resident #1 pushed on the keypad next to the exit door and pushed on the bar of the exit door that was a security barrier that kept the door locked from the outside and, temporarily for 15 seconds, from the inside. At 10:58:57 AM Resident #1 opened the exit door and walked out the door. At 10:59:08 AM the exit door closed. At 11:01:19 AM the FT walked to the exit door, entered the alarm code on keypad turning off the alarm, turned away and walked away from the exit door. During an interview on 02/27/2026 at 4:15 PM with the Administrator she said Resident #1 eloped out a back side door of the facility and traveled down the concrete ramp exit. At the bottom of the ramp Resident #1 turned right crossing a grassy yard. Resident #1 crossed a residential street with a speed limit of 30 mph. After crossing the street Resident #1 fell. Resident #1 (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
---	-------	-----------

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  03/02/2026
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)		
F 0689  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p>traveled approximately 500 ft. from the exit door to where he fell. The Administrator estimated Resident #1 was gone from the facility for about 30 minutes. Record review of www.wunderground.com reflected the weather on 02/08/2026 was cool, dry, breezy with an average temperature of 61.81 degrees Fahrenheit. Record review of HHS Facility Provider Investigative Report dated 02/08/2026 reflected Resident #1 was observed outside the facility in adjacent parking lot on the ground. Resident was assisted back to the facility by facility staff. Resident had no visible signs of injury and did not exhibit any signs of emotional stress. Facility video recording showed Resident #1 going to exit door and pushing on crash bar (a safety mechanisms installed on commercial doors to provide fast, easy, and secure egress during emergencies) until lock was released and then exited the building. Staff members responded to the door alarm to turn it off without following door alarm process. Record review of Resident #1's admission Elopement assessment dated [DATE] reflected Resident #1 was a high risk for elopement. During an interview on 02/27/2026 at 3:43 PM with the Administrator she said there were seven people working that day and anyone in the facility could turn the door alarm off, but all staff knew that they needed to open the door and look outside for a resident before they turned the alarm off and walked away. The Administrator said Resident #1 went to the door and pushed the door until it was released and the FT did not open the door to look out and check if a resident was outside. The Administrator said Resident #1 made it out the door, down a ramp into the facility parking lot and across the street and he fell. Two people in a car passing by saw Resident #1 on the ground. One of the passersby came to the laundry room and knocked on the door. The laundry person went directly to get RN B and did not go out to see Resident #1 and had no additional involvement. LVN A assessed Resident #1 and found no injuries. Resident #1 was placed on 1:1 until he was discharged to another skilled nursing facility with a secure unit. The Administrator said the facility failed to follow the elopement policy. The Administrator said if the elopement policy were not followed a resident could be seriously harmed if they eloped from the facility. During an interview on 02/27/2026 at 4:24 PM with RN B he said he was the weekend supervisor and worked on 02/08/2026 when Resident #1 eloped. RN B said someone (he did not remember the name) from the laundry room got him and said a guy outside knocked on the laundry door and said that one of their residents was across the street. RN B said the by passer-by and his wife had walked Resident #1 back to the facility (he did not get the by passers names). RN B said when Resident #1 came back into the facility, Resident #1's wander guard sounded its alarm. RN B said the Administrator came to the facility and investigated how the incident happened. RN B thought it was a problem with the door latch. RN B said that Resident #1 was not hurt and Resident #1's assessment by LVN A showed no bruises or cuts. RN B told them passersby said Resident #1 crossed the street, had fallen, and was in the dirt. The passersby were in a car driving by when they saw Resident #1 waving. RN B said Resident #1's family was called and Resident #1 was placed on 1:1 immediately. During an interview on 02/27/2026 at 4:37 PM LVN A said she assessed Resident #1 when he returned to the facility after he eloped on 02/08/2026. LVN A said Resident #1 did not have any injuries and she believed that Resident #1 was gone from the facility about 30 minutes. LVN A said Resident #1 constantly wanted to go home and that was the reason he had a wander guard. LVN A said Resident #1 had no previous elopements and he was placed on 1:1 (constant monitoring arrangement where one staff member was assigned to a single resident) for the last 3 or 4 days he was at the facility then Resident #1 was discharged to a facility with a secured unit. LVN A said if a resident eloped from the facility the resident could fall and break something or they could get run over by a car or they could get sick or die. Attempted interview by phone on 02/27/2026 at 4:42 pm with the FT. A voice mail and a text message were sent to the FT. No response received from the FT. During an interview on 02/27/2026 at 6:18 PM the ADON said if a door alarm goes off or a wander guard alarm sounds you did not just turn the alarm off. She said you should look outside and make sure no resident got out of the facility and make sure residents are accounted for. She said if a resident eloped from the facility, they could get hurt or even die. During an interview on 03/02/2026 at 1:30 PM RN A said Resident #1 was a wanderer, but he did not ask to (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  03/02/2026
NAME OF PROVIDER OR SUPPLIER  Focused Care of Waxahachie		STREET ADDRESS, CITY, STATE, ZIP CODE  1413 W Main St Waxahachie, TX 75165	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>leave or push on doors. She said except for wandering, Resident #1 did not have exit seeking behaviors prior to his elopement. During an interview on 03/02/2026 at 2:07 PM with the HOH he said before Resident #1's elopement his housekeeping staff including the FT were trained that if a facility alarm sounded, they were to look out the door and see if a resident went outside and then turn the alarm off. The HOH said if a resident left the facility a resident could get lost or get into an accident. He said a lot of things could happen if a resident eloped. He said that prior to this, he had not seen Resident #1 try to leave the facility. During an interview on 03/02/2026 at 2:20 PM with CNA A she said Resident #1 did not have exit seeking behaviors prior to the elopement. She said that if someone eloped from the facility they could get hit by a car, fall down or worse pass away. She said she received training about the alarms when she began working at the facility. CNA A said she was trained that if a door alarm went off, you needed to look outside and see if a resident went outside before the alarm was turned off. She said if someone went outside, you needed to get them back in. She said the facility had elopement training pretty regularly and they always discussed if the door alarm went off to go and checked that a resident did not leave before turning off the alarm. During an interview on 03/02/2026 at 2:42PM DON said she began working at the facility on 02/01/2026 and she did not know all the residents yet, but she assumed that Resident #1 had wandering behaviors because he had a wander guard. She said she had a chart in her office with a list of the residents with wandering behaviors and Resident #1's name was on that list. She said her expectation as the DON was that everyone should answer the door alarm by going to the door, opening the door, and looking around outside for a resident. She said if a resident eloped, they could get hit by cars; they could get lost. The DON said there was a reason residents had a wand guard and it was for their safety. Review of facility policy Risk Management Elopement dated 11/01/2019 reflected the policy was to safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Record review of Resident #1's Elopement assessment dated [DATE] reflected Resident #1 was a high elopement risk. Record review of Resident #1's Progress Notes reflected Resident #1 was discharged to another facility on 02/11/2026. Record review of all elopement assessments was conducted on 02/08/2026 for all facility residents. Seven residents were evaluated as having a high risk of elopement. Review of the seven residents care plans reflected all residents identified had a focus and interventions for high-risk elopement. Record review of in-service from HOH to FT dated 02/09/2026 reflected FT was in-serviced that all door alarms must be checked by looking outside for a resident before the alarm was turned off. Record review of facility all staff in-services dated 02/08/2026 and 02/09/2026 for Elopement Procedure: any time you turn a door alarm off, staff must check outside for residents first, policy on missing residents - what to do, who to contact, and steps to take, risk management elopement - safely and timely redirecting residents to a safe environment and facility abuse and neglect policy. Record review of facility elopement binder reflected it included a photograph of each of the residents who were identified as an elopement risk after facility wide resident elopement assessments completed on 02/08/2026. The binder included a flyer that could be presented to law enforcement and passed out to the public with the residents' current photo, name, and telephone number of the facility, name of residents' doctors. The binder included the residents' face sheets, complete resident profiles with description of each resident, mental condition and address and telephone number of relative or friend to contact, and list of residents' medications. Review of documentation of facility door alarm checks by the Administrator dated 02/08/2026 at 1:30 pm reflected that the facility front door, 200 door, 100 hall exit door 1, 100 halls exit door 2, kitchen door, 500 hall doors (all facility doors) were functioning and alarms sounded when crash bar were pushed. Review of documentation of resident wander guard checks by the DON dated 02/08/2026 reflected that all seven residents wearing wander guards activated when the residents were taken near all facility doors. During an interview on 02/27/2026 at 6:13 PM LVN C said she was in-serviced on 02/08/2026 when Resident #1 eloped. She said during the in-service it was explained that staff (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  03/02/2026
NAME OF PROVIDER OR SUPPLIER  Focused Care of Waxahachie		STREET ADDRESS, CITY, STATE, ZIP CODE  1413 W Main St Waxahachie, TX 75165	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>members do not just turn off the alarm if it is ringing. LVN C said staff should open the door and lookout to make sure no residents had gotten out of the facility. During an interview on 02/27/2026 at 6:23 PM CNA B said she was in-serviced on 02/08/2026 what to do if a resident pushed an exit door and the alarm went off. CNA B said staff should go to the scene and go outside and make sure that a resident was not out there before. She said you look for the resident before turning off the alarm. During an interview on 02/27/2026 at 6:30 PM RN B said she was in-serviced on 02/08/2026 about making sure that when an alarm goes off that staff open the door and look for a resident before turning off the alarm. She said a resident could quickly leave the facility and staff needed to make sure they did not leave the facility. Noncompliance at the IJ Level that was identified on 2/27/2026 and facility ADM was informed at 10:10 PM, 2/27/2026. The noncompliance was corrected prior to the surveyor entering the facility. The noncompliance was identified as PNC. The IJ began on 02/08/2026 and ended prior to 2/27/2026.</p>		