STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455983	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Center	300 West Highway Waco, TX 76712

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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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status for one (Resident #50) of four residents reviewed for change of condition. The facility failed to recognize a change in condition in Resident #50 on 3/13/2026 after she was reported to the CNA to be experiencing stroke like symptoms and Resident #50 was not transported to the hospital until 3/14/2026. This deficient practice could place residents at risk for injury and harm.Findings included: Record review of Resident #50's admission's record dated 4/28/2026 revealed Resident #50 was an [AGE] year-old female who was initially admitted on [DATE] was diagnosed with of unspecified sequelae of cerebral infarction (long-term complications or residual effects that occur after a stroke, when the specific consequences are not clearly identified), idiopathic peripheral autonomic neuropathy (occurs when there is damage to the nerves that control automatic body functions), hypertension (a common condition where the force of blood against the artery walls is consistently too high), gastro-esophageal reflux disease (stomach acid flows back up into the esophagus and causes heartburn). Record review of Resident #50's Quarterly MDS assessment dated [DATE] revealed Resident #50's BIMS score of 07- indicated severe impairment. Resident #50 needed substantial/maximal assistance with ADLs. Record review of Resident #50's care plan revision date on 03/20/2026 revealed The resident is at risk and/or has impaired communication related to: Change in environment. Review of a progress note dated 03/14/2026 at 2:19pm by LVN J revealed, CNA requested resident be assessed d/t change in condition. Resident has rt sided weakness, facial drooping on right side, slurring words, and per CNAs, resident is unable to assist with transfers per her usual. Resident's emergency contact was at resident's bedside. She stated that she informed staff that there was something wrong with residents yesterday. Called EMS for transport, they arrived at 2:11pm and left facility with resident at 2:15pm. In an interview on 04/28/2026 at 10:30am with Resident #50's FM, she stated that she was visiting Resident #50 on 3/13/2026 around 10 am. The FM stated she noticed Resident #50's mouth was drooping; she was slobbering and was slurring her words. She stated she told CNA L that she came to visit Resident 50 and that she looked like she was having a stroke. She stated she went to the nurses' station, and the person at the nurse's station stated it was a result of Resident #50's Parkinsons, and that there was no staff followed up by checking her vitals. She stated on 03/14/2026 Resident #50 admitted to the hospital for a stroke. In an interview on 4/28/2026 at 11:53 am, LVN A stated he was the nurse manager on Resident #50's floor. He stated Resident #50 did not have Parkinsons after looking up her diagnosis. He stated that signs of a stroke were weakness to one side and facial drooping. He stated there was no verbal or written communication of Resident #50 having any signs or symptoms of a stroke on 3/13/2026. He stated they called EMS on 3/14/2026 and she went to the hospital at 2:15 PM. In an interview on 4/28/2026 at 1:23 pm, with the IP, she stated she administered Resident #50 medications at bedtime, and she was able to swallow and take them with no problems. Resident #50 had no changes from (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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F 0580 Level of Harm - Actual harm Residents Affected - Few	when she previously seen her, which was several weeks ago when she was on a different floor (2nd floor). The IP went into Resident #50 room and reviewed her eye drops with her. There were no facial drooping or no deficits. Resident #50 had no signs and symptoms of a stroke. It was about 7:30 to 8:30 pm when she administered pills. In an interview on 4/28/2026 at 2:12 pm, the RA stated she worked with Resident #50 on the 2nd floor, and she did not notice any changes. The RA walked with Resident #50, and when the RA spoke with a CNA, did not remember which CNA, and they stated they had issues with her transferring to the wheelchair to bed and to toilet to the bed. She noted it in her notes. The RA noted Resident #50 was not feeling very well, and she was having difficulty walking. She spoke to the nurse, and she does not remember what nurse she advised of the COC with the resident. The RA stated she did not have Resident #50 too long, and it was the weekend and a relative stated they noticed something was going on. When she saw her on the second floor, she was hard to transfer then. She noticed slow speech, but it was not a whole lot. In an interview on 04/28/2026 at 3:15pm, the DON stated the family of Resident #50 had some concerns regarding a delay in seeking care. He stated that the nursing staff sent the resident to the hospital the next day. He stated that he hoped if signs and symptoms were observed of a stroke, they would have contacted the MD, which was done on the 14th. He stated that he did not interview any of his staff, he just reviewed Resident #50's chart. He said that the family brought it to the attention of a nurse (he guessed on Friday night), and the nurse told them that was a diagnosis of Parkinson's. He stated that the nurse supervisor told him that too. He stated since Resident #50's CVA she had deficits that she was working on with therapy. In an interview on 04/28/2026 at 3:15pm, the MD stated that the resident, if symptoms were identified as a stroke within 4.5 hours, it would have to be caught within a short timeframe, to determine if she would have been a candidate for the clot buster medication. He stated young people could benefit from clot busters, but for Resident #50, her age may be a contraindicator. He stated that once stroke signs and symptoms were recognized, a provider should be notified. He stated that Resident #50 had an acute CVA. In an interview on 4/30/2026 at 10:31 am, CNA L stated Resident #50 did not look right. And she advised LVN J to go check on her and she did. She said later around lunch time; she was about to take Resident #50 to the dining area, and she advised LVN J to check on her again because it appeared as if she needed to go to the hospital. CNA L stated Resident #50 appearance had changed especially her speech, it was slurred. She stated she was talking better earlier. She stated LVN J took Resident #50's vitals and assessed the resident, and they prepared to send her to the hospital. Review of the facility's policy titled Change in a Resident's Condition or Status dated 01/2026 reflected, The nurse will notify the resident health care provider or physician on call when there has been a (an):1. Accident or incident involving the resident.4. significant change in the residents' physical/emotional/mental condition.C. Prior to notifying the health care provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 6 residents (Resident #65 and Resident #137) reviewed for resident rights.The facility failed to ensure CNA B knocked on Resident #137's door before entering the resident's room.The facility failed to ensure CNA E knocked on Resident #65's door before entering the resident's room.The facility failed to ensure CNA F knocked on Resident #65's door before entering the resident's room.These failures could place residents at risk of feeling like their privacy was invaded or cause psychosocial harm and emotional distress.Findings included:Record review of Resident #65's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #65 diagnosis included cerebral infarction (stroke) affecting the left non-dominant side and unsteadiness in the feet.Record review of Resident #65's quarterly MDS assessment, dated 04/17/2026, revealed Resident #65 had a BIMS score of 12, which indicated moderate cognitive impairment.Record review of Resident #137's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #137 diagnosis included Transient cerebral ischemic attack, unspecified (mini stroke), and limitation of activities due to disability. Record review of Resident #137's quarterly MDS assessment, dated 04/17/2026, revealed Resident #137 had a BIMS score of 11, which indicated moderate cognitive impairment.In an observation and interview on 04/28/2026 at 10:43 AM with Resident #65 in her room, CNA F entered the room without knocking. Resident #65 stated that sometimes the staff knocked, and sometimes they did not.In an observation and interview on 04/28/2026 at 11:05 AM with Resident #137 in her room, LVN G entered the room without knocking. Resident #137 stated that there were times when the staff did not knock before entering. Resident #137 stated that she had not made a complaint to anyone.In an observation on 04/28/2026 at 11:23 AM of the 200 hall, CNA B was observed entering Resident #137's room without knocking.In an interview on 04/28/2026 at 11:21 AM, CNA B stated she was supposed to knock on the door before going into the room. CNA B stated that she was in a hurry and forgot. CNA B stated that if they did not knock on the door, it would be a resident rights issue. CNA B stated that the resident may be in the middle of receiving care, so they should knock on the resident's door before entering the room. CNA B stated that she had in-service training on resident rights about a month ago.In an interview on 4/30/2026 at 10:34 AM, LVN G stated that the only time you would not knock on the door was if there was an emergency. LVN G stated that if the door was open, staff still needed to knock and introduce themselves. LVN G stated if you did not knock on the door, you could have walked in while the resident was receiving patient care. LVN G stated that failing to knock on the door violated residents' rights. LVN G stated that the only reason she did not knock that time was that she had just been in that room for something else. LVN G stated that she had received in-service training on resident rights, and the last time was about a month ago.In an interview on 4/30/2026 at 10:49 AM, RN H stated he was the charge nurse for the second floor. RN H stated all staff were expected to knock on the resident's door before entering the resident's room. RN H stated he ensured this by doing rounds to make sure staff were knocking on residents' doors. RN H stated they also brought this up during their huddle before each shift. RN H stated they do yearly training and training in the education binder. RN H stated he ensured new staff were aware that they must knock on the resident door before entering. He said new staff are made aware of this in their onboarding education and training. RN H stated he had not seen any staff knock on residents' doors before entering. RN H stated if he saw that, he would remind them to knock on the resident's door. RN H stated he would re-educate staff members who did not knock on the door. RN stated he had not had any complaints from residents about staff not knocking on the door.In an interview on 4/30/2026 at 11:00 AM , CNA C (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that staff should never enter the room without knocking. CNA C stated if the door was open, she would knock on the door or the wall and verbally let them know she was going inside. CNA C stated knocking was necessary if the resident was receiving patient care at the time. CNA C stated that she had not witnessed any other staff member fail to knock on the door before entering a residents' room. CNA C stated that if she saw another staff member not knocking before entering a room, she would remind them. CNA C stated that she had in-service training on residents' rights about a month ago.In an interview on 4/30/2026 at 11:08 AM, CNA D stated that staff were instructed to always knock unless there was an emergency. CNA D stated that even when the resident's door was open, staff still knocked and identified themselves to the residents. CNA D stated she had not witnessed staff failing to knock on doors, residents' doors, and if she did, she would remind staff to knock. She said resident's rights and privacy were discussed a month ago. She stated when rushed, she had at times forgotten to knock.In an interview on 4/30/2026 at 11:15 AM, LVN A stated he was the charge nurse on the third floor, and he did random rounds to check and observe staff knocking on residents' doors. LVN A stated he had not witnessed staff not knocking on doors before entering the residents rooms. LVN A stated he had in-serviced on resident rights last year. LVN A stated that all new staff were made aware of this policy during orientation upon hire. LVN A stated he had not witnessed any staff failing to knock on doors before entering rooms. He stated if he witnessed a staff member not knocking on the door, he would remind them and then reeducate them. LVN A stated he had not heard any complaints from residents, saying that staff were not knocking on their doors.In an interview on 04/30/2026 at 11:27 AM, the DON stated that all staff were expected to knock on residents' doors before entering. The DON stated if staff were not knocking on doors, it was a resident rights and privacy issue because residents could be in the middle of patient care. The DON stated he made rounds to ensure staff were following these procedures. The DON stated that in the past, there was an issue with staff not knocking on doors, but he had not heard of anything recently. The DON stated that he had not witnessed any staff not knocking on doors, but if he saw staff not knocking on doors, he would stop them and remind them. The DON stated he would conduct education with the staff, about the importance of knocking on resident's doors before entering.Review of the facility's policy titled ?Quality of Life - Dignity', dated 12/2021 reflected, 1. Associates will knock and request permission before entering residents' rooms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed. The facility failed to ensure Dietary Staff performed good hand hygiene within the context of food handling and sanitation. This failure could place residents at risk of cross contamination and the potential transmission of infectious organisms. Findings included: An observation on 04/28/2026 at 11:45AM during lunch DA M was observed picking up a hamburger patty with her hands. It was observed that she was not wearing any gloves or using any utensils to remove the meat from the pan. In an interview on 04/30/2026 at 10:13AM, DA M stated her job description stated her job description is to set up trays, serve the residents, and clean the dining area. She started to pick up the meat rushing. She stated at some point they told them they did not have to wear gloves. She stated that it is not normal practice to pick up food with her hands. She stated a negative outcome could spread germs and someone can get sick. In an interview on 04/30/2026 at 10:18 AM, DA N stated her job description is to serve the residents, check temperatures on the food, fixing drinks, making sure their food trays match their meal tickets, clean the dining area, sweep and wipe the tables. She stated they should wear gloves while handling food and washing their hands before, during and after handling food. She stated a negative outcome was that someone could get sick and get cross-contamination. In an interview on 04/30/2026 at 10:45 AM, CK O stated her job duties include but are not limited to cooking all diets such as regular, mechanical, and puree diets, she starts lunch meats and gravies. She stated sometimes you might forget to put gloves on, but you are handling food so you should wash and put gloves on immediately. She stated she tries to watch everyone when they are handling food to make sure, they have on gloves. She stated that it is not normal practice to handle food without gloves. CK O stated handling food inappropriately can cause cross-contamination, and you will have messed up a whole pan of food. She stated her expectations for her staff is to be the best. She stated she would help them out. She tells them if they will not eat it don't give it to anyone else. In an interview on 04/30/2026 at 11:05 AM, the DIR stated his job duties included keeping the kitchen a flow, making sure the right food was going in and out of the kitchen to the residents, and making sure the right staff was in place to do the job. The DIR stated a couple of months ago, they came out with a new rule they wanted all staff to use tongs, and they did not have to wear gloves. He stated then corporate came back and said it was a mistake and to continue wearing gloves. He stated that was why DA M might have been confused. He stated no food should have been picked up with her bare hands. A negative effect could be cross-contamination, germs, bacteria, sickness, or worse. The DIR stated his expectation from has staff was to always be prepared and wear their gloves. Clean their utensils. This is older folks and their immune system is not what it used to be. Review of facility policy titled Food Handling Guidelines (HACCP) revision date January 2024, stated Food should be protected against cross-contamination by appropriately separating types of raw animal products such as beef, lamb, pork and poultry during storage and processing with the use of separate equipment or areas or by scheduling and cleaning; and appropriately separating raw (potentially hazardous) foods from ready-to-eat food products during storge, preparation, and/or service. Raw, unwashed produce is stored separately from washed, ready-to-eat foods. Cutting boards and other food contact surfaces are cleaned and sanitized between different food preparation steps. The following three-color cutting board system is standard: green boards are used for washed produced, red for all raw animal foods, and white for all cooked and ready-to-eat foods. Chemicals, including red buckets sanitizer solutions, are not stored where food is prepared (example, on the food preparation table). 1.) Hands should be scrubbed following appropriate hand-washing techniques according to facility/community policy (e.g., after toilet use, between food preparation tasks, before putting on gloves, etc.).

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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** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (Resident #119) of seven residents reviewed for ADL care.The facility failed on 04/28/2026 to ensure they cleaned Resident #119's motorized wheelchair for an indeterminant amount of time. This failure could place residents at risk of infection, and loss of dignity.Findings included:Record review of Resident #119's comprehensive MDS assessment dated [DATE] reflected, a [AGE] year-old male who admitted to the facility on [DATE]. Diagnoses included: coronary artery disease (narrowing or blockage of the coronary arteries due to plaque buildup), high blood pressure, kidney failure, diabetes mellitus (chronic condition where the body cannot properly use blood sugar), high cholesterol (elevated levels of cholesterol in the blood), legal blindness, and morbid obesity. Resident #119 was coded under functional abilities as having impairment on both sides of his lower extremities, he used a motorized wheelchair. Resident #119 had a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #119's comprehensive care plan dated 04/29/2026 reflected Resident #119 was at risk for acquiring or transmitting infection due to wounds, at risk for pressure ulcers and/or impaired skin integrity, and he needed assistance with daily ADL care.In an observation and interview on 04/28/2026 at 10:59 AM, Resident #119 was observed with 2 above the knee amputations. He was sitting in a motorized wheelchair that was visibly soiled with debris all over the footrest, the arm rests, the plastic above the wheels, and the visible portion of the seat cushion. Resident #119 stated he was legally blind. He stated he was not receiving rehabilitation presently, because they were waiting on his inner left thigh wound to heal. He stated the staff did not normally clean his wheelchair, nor did they offer to clean it. He stated he had not asked staff to help him clean it because he did not know they would do that for him. He stated at home he would get on the ground and clean it off, but since he did not have his left leg anymore, he could no longer do that on his own. He stated he dropped a piece of meat on it yesterday. An observation of a golf ball sized red/brown goo was observed at the bottom of the wheelchair near the footrest. He stated he had been using his motorized chair for 7 months, and he did not recall anyone offering or telling him they were cleaning his wheelchair. He stated he felt partly responsible for it being dirty because he did not ask anyone to clean it for him. In an interview on 04/30/2026 at 10:15 AM, the IP stated she could not remember the exact protocol for cleaning and disinfecting resident-owned equipment like motorized wheelchairs, but she knew they needed to be cleaned once weekly on a certain shift, by CNA's. She stated from an infection control standpoint, she had not identified any issues with equipment cleanliness, but that all staff were educated on cleaning and disinfecting shared equipment between resident use. She stated that appropriate cleaning supplies were readily available in the shower rooms. She stated that barriers to cleaning motorized wheelchairs could be the electronic components, and the residents being in their chairs a lot. In an interview on 04/30/2026 at 1:45 PM, LVN A stated he had worked at the facility for 21 years. He stated he was unsure if they had a policy on cleaning motorized wheelchairs, but the protocols they had in place was that they were cleaned at night, by CNA's. He provided a schedule that had rooms assigned on certain days, for the wheelchairs in those rooms to be cleaned. He stated that those schedules were posted at every nurse's substation. He stated there was nowhere the CNA's indicated that the task had been completed, whether on paper or on the computer. He stated he ensured the wheelchairs were being cleaned by spot checking them during rounds. In an interview on 04/30/2026 at 2:10 PM, CNA I stated she had worked at the facility for approximately 6 months. She stated that most of the time she would clean wheelchairs if she noticed they were dirty, but technically it was night shift CNA's responsibility to clean. She stated she recalled prior shifts she worked where she had washed off Resident #119's chair while he showered (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	himself, and that was about 3 weeks ago. She stated the importance of cleaning resident wheelchairs would be so they worked properly, resident dignity, and risk of infection since Resident #119 has sores on his leg. She stated she was still learning the charting system so she was not familiar with a place to notate it. In an interview on 04/30/2026 at 2:17 PM, LVN J stated she had worked at the facility for a little over a year. She stated nightshift CNA's were responsible for cleaning resident wheelchairs. She stated they did not write down that the task was completed. She stated that she had never noticed Resident #119's wheelchair being dirty, and she was not sure when it was last cleaned. She stated that if she noticed it was dirty she would delegate the task to one of the CNA's. She stated there were sanitary issues if it was not cleaned, and risk of infection because his skin touched the wheelchair, and he had diabetic ulcer's. In an interview on 04/30/2026 at 2:25 PM, CNA K stated she worked at the facility for approximately 2 years. She stated that everybody was responsible for cleaning wheelchairs if they were noticeably dirty, but night shift was primarily responsible. She stated that it had been awhile since she had worked with Resident #119, but that his wheelchair got dirty a lot because he had vision impairments and would drop food on himself and the chair. She stated that he had visitors and would go outside and it would get dirty from being outside, but she was unsure how often he went outside. She stated that dirty wheelchairs could cause infection, especially when he got in and out of the chair, he could scrape over the food and it was unsanitary. She stated there was nowhere to document that they had cleaned resident wheelchairs, there was a wheelchair cleaning chart, but it was not used for documentation. In an interview on 04/30/2026 at 2:34 PM, the DON stated he had worked at the facility for 18 years. He stated their policy did not specify the cleaning and disinfecting requirements for resident-owned equipment like motorized wheelchairs, but their procedure was to wash resident wheelchairs once a week, at night by the CNA's. He stated they had a schedule by room number, that they went by for wheelchair cleaning. He stated they monitored cleanliness through general spot checks and rounding. He stated they could not show how it was being implemented for Resident #119, because they did not have staff document the task. He stated that negative impacts could be dignity issues, because despite Resident #119's vision impairment, he could tell when his wheelchair was dirty, and it was an infection control issue. Review of the facility policy titled ?Cleaning and Disinfection of Resident-Care Items and Equipment' dated 06/2025 reflected: Resident-care equipment can be a source of indirect transmission of pathogens. 3. Direct care staff are responsible for cleaning single-resident equipment when visibly soiled, and according to routine schedule (where applicable).