

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER The Brazos of Waco		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 Market Place Drive Waco, TX 76711	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on interviews and record review, the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for three (Resident #1, Resident #2, and Resident #3) of six residents reviewed for quality of care.</p> <p>The facility failed to weigh Residents #1, #2, and #3 according to physician orders.</p> <p>This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including congestive heart failure, edema (swelling), hypertension (high blood pressure), and type II diabetes.</p> <p>Review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 14, indicating no cognitive impairment.</p> <p>Review of Resident #1's admission care plan, dated 12/30/24, reflected she was at risk of nutrition and/or dehydration with an intervention of monitoring weights, skin report, and labs per policy.</p> <p>Review of Resident #1's physician order, dated 12/26/24, reflected daily weights.</p> <p>Review of Resident #1's weights in her EMR, from 12/26/24 - 01/08/25, reflected she was weighed on 12/26/24, 12/29/24, 01/01/25, 01/07/25, and 01/08/25.</p> <p>Review of Resident #2's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including acute kidney failure, congestive heart failure, generalized edema, and hypertension.</p> <p>Review of Resident #2's admission MDS, dated [DATE], reflected a BIMS score of 3, indicating a severe cognitive impairment.</p> <p>(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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's admission care plan, dated 12/18/24, reflected he was at risk of nutrition and/or dehydration risk with an intervention of monitoring weights, skin report, and labs per policy.</p> <p>Review of Resident #2's physician order, 01/03/25, reflected daily weights.</p> <p>Review of Resident #2's weights in his EMR, from 12/18/24 - 01/08/25, reflected she was weighed on 01/04/25.</p> <p>Review of Resident #3's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including type II diabetes, congestive heart failure, morbid obesity, and pressure ulcers.</p> <p>Review of Resident #3's quarterly MDS, dated [DATE], reflected a BIMS score of 14, indicating no cognitive impairment.</p> <p>Review of Resident #3's quarterly care plan, dated 12/16/24, reflected she was at risk of nutrition and/or dehydration with an intervention of monitoring weights, skin report, and labs per policy.</p> <p>Review of Resident #3's physician order, dated 08/13/24, reflected daily weights.</p> <p>Review of Resident #3's weights in her EMR, from 11/01/24 - 01/08/25, reflected she was weighed on 11/01/24, 12/04/24, 12/10/24, and 01/01/25.</p> <p>During an interview on 01/08/25 at 2:57 PM, the DON stated physician orders should always be followed. She stated it was her expectation for the admitting nurses were expected to weigh a resident upon admission and then nurses were to weigh weekly or daily - whichever was ordered. She stated it was important for a resident with a diagnosis of CHF to be diagnosed as ordered so weight gain could be monitored (to ensure no excess fluid was on the heart). She stated a negative outcome of not weighing residents regularly could be exacerbation of health conditions.</p> <p>Review of an in-service entitled Weights, dated 11/11/24 and conducted by the DON, reflected the following:</p> <p>Nursing and Aides: We have several residents on daily and weekly weights. The weights must be collected in order to track our residents' weights. This is IMPORTANT to collect the weight on the day it is due.</p> <p>Review of the facility's Physician Orders Policy, revised May 5, 2023, reflected it did not address the importance of following physician orders.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practice for three (Resident #2, Resident #4, and Resident #6) of six residents reviewed for respiratory care.</p> <p>The facility failed to:</p> <ul style="list-style-type: none"> - Ensure Resident #2 had an order for oxygen therapy or had an Oxygen in Use sign on the door to his room. - Ensure Residents #4's oxygen tubing not in use was bagged and off the floor of their room. - Ensure Resident #4 was not eating lunch in the dining room utilizing oxygen with an empty oxygen tank. - Ensure Resident #6's nasal cannula tubing was connected to the concentrator and water was in the cannister. <p>These deficient practices could place residents that receive oxygen therapy at risk for inadequate care and respiratory infection.</p> <p>Findings Included:</p> <p>Review of Resident #2's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including acute kidney failure, congestive heart failure, generalized edema (swelling), and hypertension (high blood pressure).</p> <p>Review of Resident #2's admission MDS, dated [DATE], reflected a BIMS score of 3, indicating a severe cognitive impairment. Section O (Special Treatments, Procedures, and Programs) reflected he did not required any respiratory treatments.</p> <p>Review of Resident #2's admission care plan, dated 12/18/24, reflected no problems or interventions for oxygen therapy.</p> <p>Review of Resident #2's physician orders, on 01/08/25, reflected no orders for continuous oxygen.</p> <p>Observation on 01/08/25 at 11:05 AM revealed Resident #2 asleep in his room utilizing an oxygen concentrator with the cannula in his nose. There was no Oxygen in Use sign on the door to his room.</p> <p>Review of Resident #4's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a disease that was characterized by persistent respiratory symptoms), presence of cardiac pacemaker, hypertension, and dysphagia (difficulty swallowing).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #4's quarterly MDS assessment, dated 12/06/24, reflected a BIMS score of 15, indicating no cognitive impairment. Section O (Special Treatments, Procedures, and Programs) reflected he did not require any respiratory treatments.</p> <p>Review of Resident #4's quarterly care plan, dated 10/28/24, reflected he required oxygen by nasal cannula at 2-4 L per minute continuous with an intervention of O2 equipment turned on accurately, connected properly, and set to the correct setting (flow rate).</p> <p>Review of Resident #4's physician order, dated 10/18/24, reflected O2 at 2-4 liters per minute via nasal cannula to keep sats >90%.</p> <p>Review of Resident #4's physician order, dated 10/18/24, reflected keeping O2 cannula/mask/tubing and/or nebulizer mask/tubing bagged when not in use.</p> <p>Observation on 01/08/25 at 10:22 AM revealed Resident #4 asleep in his room utilizing his oxygen concentrator. He had an oxygen tank on the back of his wheelchair that was empty with the tubing not bagged and on the floor. He had a nebulizer mask on his bedside table that was not bagged.</p> <p>During and observation and interview on 01/08/25 on 12:56 PM revealed Resident #4 eating lunch in the dining room. He had his oxygen nasal cannula in his nose and the oxygen tank on the back of his wheelchair was empty. He stated his oxygen was working okay.</p> <p>During an interview on 01/08/25 at 1:02 PM, LVN A stated she noticed Resident #4's oxygen tank was empty when she took him to the dining room, but she had taken his oxygen saturations and they were at 93% and he did not require oxygen unless his saturations were under 93%.</p> <p>During an observation and interview on 01/08/25 at 1:04 PM, CNA B stated Resident #4 always needed to be receiving oxygen. When she noticed his tank was empty, her eyes went wide, and she called for LVN C for assistance. LVN C took Resident #4's oxygen saturations which was at 91%. She left to go get him a full oxygen tank after stating he needed to always have oxygen on.</p> <p>Review of Resident #6's undated face sheet printed 01/08/24, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), vascular dementia with anxiety, neuromuscular dysfunction of bladder (nerve damage impairing bladder control), and coronary artery disease (narrowing of the vessels that carry blood to the heart).</p> <p>Review of Resident #6's quarterly MDS assessment dated [DATE], reflected a BIMS score of 7 indicating severely impaired cognition. Section O (Special Treatments, Procedures, and Programs) reflected she required oxygen therapy.</p> <p>Review of Resident #6's comprehensive care plan, revised 01/08/24 reflected, Problem: Resident is on 2-4 liters of oxygen per minute via NC . She likes to take it off often times during the day. Goal: Have improved lung sounds, maintaining healthy diet, have a target O2 SAT level between 94% and 98%. Approach: Encourage Resident #6 to leave her oxygen tubing in place. Explain that it helps her to breathe. O2 equipment should be turned on, connected properly, and set to the correct flow rate and to monitor O2 levels. [sic]</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #6's physician order dated 11/25/24 reflected, O2 at 2-4 liters per minute via nasal cannula prn to keep sats greater than 90% every shift prn.</p> <p>During an observation on 01/08/25 at 10:15 AM, Resident #6 was lying in bed with the head of the bed elevated. She was wearing a nasal cannula. The oxygen concentrator next to her bed had a water cannister attached. The cannister did not contain any water. The cannula tubing was dated with a piece of tape. The tape was stuck to a baggie that was hanging from the concentrator. The end of the nasal cannula tubing was not attached to the oxygen concentrator.</p> <p>An observation and interview on 01/08/25 at 10:23 AM revealed LVN C, donned PPE and entered Resident #6's room. She informed the resident that she was going to check her oxygen saturation. She checked and reported a result of 92%. LVN C took the water canister and filled it with tap water from the bathroom. She returned the cannister and attached it to the concentrator. LVN prepared to leave the room. When asked if she had any other concerns with oxygen set up other than the empty water canister, she returned to the concentrator and found the nasal cannula tubing was not connected to the concentrator. LVN C stated she had made rounds earlier and the oxygen had been connected. She stated she did not know how the tubing became disconnected but though maybe the resident had pulled on the tubing. She stated not having the tubing connected could have resulted in the resident's oxygen level dropping.</p> <p>During an interview on 01/08/25 at 2:57 PM, the DON stated she believed the rule to have an oxygen in use sign outside the room of a resident who utilized oxygen had gone away years ago because it was a dignity issue. She stated residents on continuous oxygen that leave the room more often had tanks in their rooms. She stated she would hope the aides would check the tanks to ensure they were not empty before a resident left the room. She stated it was everyone's responsibility of making sure tanks were full. She stated if tubing was not in use in a resident's room it should be bagged. She stated it was to prevent a resident from walking over it and prevent infection control issues. She stated if a resident was on continuous oxygen they should probably have a physician's order for it. She stated Resident #4 did not necessarily need oxygen on when not in his room. She stated it was her expectation that oxygen would be administered as ordered by the physician, the tubing be correctly attached, and the resident be monitored. She stated water was not necessary for the concentrators because it did not mess with the delivery of the oxygen.</p> <p>Review of the facility's Oxygen Therapy Policy, revised 02/12/24, reflected the following:</p> <p>Oxygen administration increases blood oxygen content so that the heart doesn't have to pump as much blood per minute to meet tissue demands.</p> <p>.</p> <p>Verify the provider's order for the oxygen therapy; all orders for oxygen therapy will include administration modality, liter flow, continuous or as needed (PRN). PRN orders will include the specific guidelines as to when the patient/resident is to use oxygen.</p> <p>.</p> <p>Check the patient's/resident's room to make sure it's safe for oxygen administration, place oxygen precautions sign on the door of the patient's/resident's room.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for two of five residents (Resident #3 and Resident #6) reviewed for infection control.</p> <p>CNA D failed to wear PPE while providing care to resident #3 who was on Enhanced Barrier Precautions.</p> <p>LVN C used a pulse oximeter (a device that measures the amount of oxygen in the blood) on Resident #6, who was on Enhanced Barrier Precautions, then failed to clean or sanitize the oximeter before placing it back in her pocket.</p> <p>These failures could place residents at risk for spread of infection.</p> <p>Findings included:</p> <p>Review of Resident #3's face sheet printed 01/08/24, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included coronary artery disease (narrowing of the vessels that carry blood to the heart), heart failure, and diabetes mellitus type 2 (a condition that affects the way the body processes blood sugar).</p> <p>Review of Resident #3's quarterly MDS assessment dated [DATE], reflected a BIMS score of 14 indicating intact cognition.</p> <p>Review of Resident #3's physician order dated 11/11/24 reflected, Resident is on EBP precautions for wound to buttock.</p> <p>Review of Resident #3's comprehensive care plan, last reviewed/revised 01/08/24 reflected the problem, Resident is on EBP precautions for wound to buttocks. The goal reflected, Resident remain infection free. The approach reflected, Staff wears PPE during direct patient care.</p> <p>Review of Resident #6's face sheet printed 01/08/24, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), vascular dementia with anxiety, neuromuscular dysfunction of bladder (nerve damage impairing bladder control), and coronary artery disease (narrowing of the vessels that carry blood to the heart).</p> <p>Review of Resident #6's quarterly MDS assessment dated [DATE], reflected a BIMS score of 7 indicating severely impaired cognition.</p> <p>Review of Resident #6's physician order dated 11/11/24 reflected, Resident is on EBP for catheter use.</p> <p>Review of Resident #6's comprehensive care plan, last reviewed/revised 01/08/25 reflected the problem, Resident is on EBP precautions for catheter use. The goal reflected, Resident stays infection free. The approach reflected, Staff wears PPE during direct patient care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 01/08/25 at 10:01 AM revealed Resident #3's room door was open, but the privacy curtain closed. Below the level of the curtain, two sets of lower legs and feet, very close together, were visible. A staff member stepped from behind the curtain. She was wearing gloves and had a bag of trash in one hand. She verified she was providing care to Resident #3. A sign on the door indicated Enhanced Barrier Precautions were in effect. The sign had pictures of the PPE required when providing care. To the left of the doorway there was a cart that contained PPE supplies.</p> <p>During an interview on 01/08/25 at 10:09 AM, CNA D came out of Resident #3's room. She stated she had been helping the resident and assisted her to the bedside commode. She confirmed that she had received training on EBP and infection control. She stated when the resident was on EBP, you had to wear a gown, mask, and gloves when providing care. CNA D stated she did not wear a gown or mask when providing care to Resident #3. She stated she did not see the sign on the door, so she did not know to wear the PPE. She stated not following infection control protocols could spread infections.</p> <p>An observation and interview on 01/08/25 at 10:23 AM revealed LVN C, without first performing hand hygiene, donned a mask, gown, then gloves and entered Resident #6's room. She informed the resident that she was going to check her oxygen saturation. LVN C put her gloved hand under the isolation gown and checked multiple pockets until she found the pulse oximeter. She checked and reported a result of 92%. She then reached under the isolation gown again and placed the oximeter back in her pocket. She completed a couple other tasks, doffed the PPE, and exited the room. LVN C stated they had frequent trainings regarding infection control, and she had been trained on EBP. When asked about the procedure for cleaning equipment used on more than one resident, such as a blood pressure cuff or an oximeter, she stated she had to go back to her cart at the nurses' station to get a wipe because they don't keep wipes near the rooms. She stated she would clean the oximeter then. When asked how she cleaned her pockets, she stated she used a wipe for the pocket too.</p> <p>During an interview on 01/08/25 at 2:07 PM, the ADON stated it was her expectation, that when providing care to a resident on EBP, staff would wear PPE including a mask, gown, and gloves. She stated anyone with things such as a catheter, a dialysis port, a colostomy, or a g-tube should be on EBP. She stated not wearing PPE or not following infection control practices could get people sick or spread infection. She stated as the Infection Preventionist, she was responsible for monitoring infections. She stated both her and the DON were responsible for training the staff about infection control. She stated CNA D had been trained on EBP recently, but she was unable to find the document at the time of the interview. She stated she had told staff not to put equipment in their pockets. The wipes were used for sanitizing, and you had to be aware of the dry time listed on the label.</p> <p>During an interview on 01/08/25 at 2:57 PM, the DON stated it was her expectation that infection control practices were followed. She stated anyone with a wound or a line such as a catheter, gastric tube, or intravenous catheter, should be on EBP. When staff provided care to those residents, she expected a mask, gown, and gloves to be worn. She stated purple top wipes were available and nurses had them on their carts. She expected those wipes to be used to clean the equipment. She stated it was not acceptable to put equipment in pockets and it was not okay to use a sanitizing wipe to clean a pocket. She stated the ADON did most of the infection control training and monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the policy, Isolation/Precautions Including Standard/Universal Precautions, and Enhanced Barrier Precautions, revised 08/25/22, reflected in part, . 1. A. EBP will be implemented for all residents with the following: .2) Wounds and/or indwelling medical devices (central lines, urinary catheter .) regardless of MDRO colonization status. B. EBP will be implemented during the following high-contact resident care activities: 1) Dressing 2) Bathing/showering 3) Transferring 4) Providing hygiene 5) Changing linens 6) Changing briefs or assisting with toilet 7) Device care or use: central lines, urinary catheter, feeding tube, tracheostomy/ventilator. C. EBP requires the following PPE: 1) Gloves 2) Gown 3) Face protection if performing activity with risk of splash or spray 4) All PPE is donned and doffed with appropriate hand hygiene and disposable after individual use or when visibly soiled .F. The facility will post clear signage on the door or wall outside of the room indicating the type of precaution and required PPE (gowns and gloves) G. The facility will post signage that clearly indicates the high-contact resident care activities that require the use of gown and gloves .</p> <p>Review of the CDC website https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, accessed on 01/08/25, reflected in part, Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p>		