STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676409	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Brazos of Waco	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)
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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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 resident's physician following an incident that occurred on 08/09/2025 at 4:30PM in the Dining Room, when Resident #4 was attempting to get a cup of coffee. The cup overflowed and spilled coffee in Resident #4s lap, resulting in Resident #4 sustaining 3 blisters to the left upper thigh. The facility failed to notify Resident #4's physician when he sustained burns from hot coffee, he spilled in his lap. This deficient practice could place residents at risk of not receiving adequate and timely intervention. The findings include: Record review of Resident #4's undated Face Sheet reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, unspecified (brain tissue death caused by a blocked artery supplying blood to the brain, leading to a lack of oxygen and nutrients) and Hemiplegia (the total or severe loss of motor function on one side of the body, resulting in paralysis) and Hemiparesis (weakness on one side of the body, affecting the arm, leg, or face) following cerebral infarction affecting right dominant side. Record review of Resident #4's quarterly MDS, dated [DATE] reflected a BIMS score of 12 (moderate cognitive impairment) and in Section G, the need for a low level of supervision in the form of staff oversight, with encouragement or cueing with eating or drinking. Record review of Resident #4's Care Plan, last updated 08/18/2025 reflected that Resident #4 requires some minimal assistance with ADLs, and he does not ask for help and often time refuses to allow staff to help him, History of CVA with right hemiparesis, Current. Care Planned interventions include the following:Approach: Eating: Assist of 1 staff member. Record Review was conducted of Resident #4's medical record. A progress note entered by LVN D on 08/09/2025 at 6:30PM, described how Resident #4 spilled coffee in his lap and LVN Ds assessment of Resident #4 who denied any injury. There was no documentation of notification of the physician or the DON in the progress note. During an interview with DA C conducted on 08/20/2025 at 2:38PM, she stated she saw Resident #4 trying to get coffee and she tried to help. DA C stated there was a lid on the cup, but it spilled anyway, and DA C reported the event immediately to the nurse. During an interview with the DON on 08/20/2025 at 4:45PM, the DON stated she was not notified of the event until the following day. She stated had she been notified; she would have ensured Resident #4's physician was notified. The DON stated she implemented corrective action with LVN D for not notifying the physician and the DON. Record review of the facility investigation report dated 08/15/2025 was performed on 08/20/2025. The report indicated the facility investigation findings as unconfirmed. There is also documentation of the following: Nursing Staff in services on Abuse, Neglect/Misappropriation, Hot Beverage Policy, Burn Policy and Proper Notification to the DON and Administrator, The Administrator, DON, and Dietary Manager were in serviced on Guidelines to Reduce the Risk of Burns from Hot Beverages, Dietary staff were in serviced on measuring the temperature of coffee and placing a sticker on the coffee pots with the date and temperature of the coffee, and One on one Inservice with LVN D regarding reporting incident/change of condition to the DON/Designee. Documentation of the Personnel action was present and reflected the signature of LVN D. Record Review of in-service dated 08/11/2025 reflected 20 staff had been in-serviced on notification of resident change. Our ability to ensure trust is paramount in what we do daily, and by keeping lines of communication open and involving the resident and their responsible party/emergency contact in the care we are providing; we build that foundation. It is REQUIRED to notify residents, responsible parties, or an emergency contact of any changes that occur with our residents. Responsible Party (RP) or an emergency contact if resident is their own RP will be notified of any changes at the time of occurrence and be DOCUMENTED in the progress notes.Record Review of in-service dated 08/11/2025 reflected 14 staff had been in-serviced on notification to the director of nursing but there was no mention of notification of the physician. Communication is crucial for proper management of nursing facilities and notification of the Director of nursing is imperative. You are required to notify the Director of Nursing and or designee for the following immediately: Incidents and Accidents with C/O Pain or Observed Injury BurnsSafety Hazards / Equipment Malfunction Record Review of in-service dated 08/12/2025 reflected 22 staff had been in-serviced on burns. Burns are a major incident in nursing homes and can cause serious negative out comes. Any burn injuries are required to have the provider assigned, DON, RP, and administrator notified immediately no matter the severity of the burn. Record Review of facility wound care policies and procedures revision date 06/01/2015 reflected all burns and scalds will be seen by a physician or a nurse as soon as possible for appropriate treatment. The purpose is to provide immediate first aid when

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #4) reviewed for accidents, hazards, and supervision, in that: The facility failed to provide adequate supervision to prevent injury for an incident that occurred on on 08/09/2025 at 4:30PM in the Dining Room, Resident #4 was attempting to get a cup of coffee. The cup overflowed and spilled coffee in Resident #4's lap and resulted in urns with 3 blisters to the left upper thigh. The facility failed to take the temperature of the coffee and keep temperature logs of the coffee. The facility failed to assess other residents for hot liquids An (IJ) Immediate Jeopardy was identified on 08/26/2025. The IJ template was provided to the ADM on 08/26/2025 at 7:28PM. While the IJ was removed on 8/28/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. Findings included: Record review of Resident #4's undated Face Sheet reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, unspecified (brain tissue death caused by a blocked artery supplying blood to the brain, leading to a lack of oxygen and nutrients) and Hemiplegia (the total or severe loss of motor function on one side of the body, resulting in paralysis) and Hemiparesis (weakness on one side of the body, affecting the arm, leg, or face) following cerebral infarction affecting right dominant side, diabetes, Hypertension, Burn of unspecified degree of left thigh Record review of Resident #4's quarterly MDS, dated [DATE] reflected a BIMS score of 12 (moderate cognitive impairment) Section G of the MDS reflected for eating and drinking resident# 4 required the need for supervision, oversight, encouragement and cueing. Record review of Resident #4's Care Plan, last updated 08/18/2025 reflected that Resident #4 required some minimal assistance with ADLs. History of CVA with right hemiparesis, Current. Care Planned interventions include the following: Approach: Eating: Assist of 1 staff member.During an interview with DA C conducted on 08/20/2025 at 2:38PM, she stated she saw Resident #4 trying to get coffee and she tried to help. DA C stated there was a lid on the cup, but it spilled anyway, and DA C reported the event immediately to the nurse. During the verbal assessment performed by the nurse, Resident #4 denied any injury. DA C stated she was in-serviced on removing the coffee servers from the Dining Room and placing them in the locked Nutrition Room after each meal service and the dietary staff are not to bring the coffee into the Dining Room unless nursing staff are present. On 08/20/2025 at 2:42PM, conducted a phone interview with the Dietary Manager. The Dietary Manager confirmed the coffee available for self-service to the residents prior to Resident #4 receiving the burn injury was not temperature tested. On 08/20/2025 at 3:13PM conducted an interview with LVN E. She stated Resident #4 informed her about the burns to his legs on the day following the event. LVN E stated she assessed the leg on 08/10/2025 at 7:27AM and obtained orders for care of the wounds and notified the DON. She stated she did find 3 open areas that appeared to be blisters that had burst. Record review of Resident #4's progress note dated 08/09/25 at 6:30 PM Recorded as Late Entry on 08/12/2025 at 08:53 AM- reflected Resident found in dining room with pants wet with coffee. Resident assessed for pain and burn. Resident reported not feeling pain or burn. Resident reported I'm fine I don't feel burn right now. Resident continued with process of getting coffee and returned to room. Record Review on 8/20/2025 of the progress note dated 08/09/2025 at 6:30PM written by LVN D regarding the coffee spill. LVN D documented that she asked the resident if he was injured, and Resident #4 denied being injured. Record review of Resident #4's incident report dated 08/10/25 reflected incident date 08/09/2025 resident was observed in the dining room with pants wet with coffee. Resident reported trying to get coffee with kitchen staff assistance. Resident assessed immediately for pain and burn. Resident reported not feeling pain or burn stating I'm fine I don't feel any pain. Resident proceeded with getting another cup of coffee and returning to his room.Record review of Resident #4's progress note dated 08/10/25 at 6:00 PM [Recorded as Late Entry on 08/12/2025 at 08:51 AM] reflected Resident reported dressing came off. Assessed skin and affected area. Skin appears pink and moist. Changed dressing. Resident reported feeling pain during procedure. Resident was given PRN acetaminophen. Cleaned skin with normal saline and gauze. Xeroform Petrolatum dressing placed on affected area. Covered dressing with Non adhesive super absorbent wound dressing and secured with skin tape. Assessed resident for discomfort. Resident tolerated procedure with no