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	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Brazos of Waco	2430 Market Place Drive Waco, TX 76711

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 5 residents (Residents #39, #42, and #57) reviewed for comprehensive assessments. The facility failed to complete an accurate quarterly comprehensive assessment dated [DATE] for Resident #39 by not including hospice services. The facility failed to complete an accurate annual comprehensive assessment dated [DATE] for Resident #42 and failed to complete an accurate admission comprehensive assessment dated [DATE] for Resident #57 by not including an antiplatelet medication and incorrectly including an anticoagulant medication. This failure could place residents at risk of not having their care and treatment needs assessed to ensure necessary care and services were provided. The findings included: Record review of Resident #39's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included: cerebral infarction (a pathologic process that results in an area of dead tissue in the brain), anxiety (intense, excessive, and persistent worry and fear about everyday situations), hyperlipidemia (abnormally high levels of any or all fat cells in the blood), and dysphagia (difficulty in swallowing). Record review of Resident #39's Quarterly MDS assessment dated [DATE], reflected that Resident #39 had a BIMS score of 07 which reflected the resident was severely cognitively impaired. Resident #39's Quarterly MDS assessment reflected that the resident was not receiving hospice services. Record review of Resident #39's Physician's Orders, dated 12/18/24, reflected the resident had an order to admit to hospice on 08/08/24. Record review of Resident #39's care plan dated 08/20/24 reflected Resident #39 was on end of life hospice services. Goal: Resident will experience death with dignity and physical comfort. Advanced directive wishes will be honored. Interventions included: Communicate with hospice when any changes are indicated to the plan of care. Notify hospice when there is any change in the resident's condition. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #42's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #42 had diagnoses which included: atherosclerotic heart disease of native coronary artery (coronary artery disease) (heart disease involving the reduction of blood flow to the cardiac muscle due to a build up of atheromatous plaque in the arteries of the heart), dysphagia (difficulty in swallowing), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), and congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs). Record review of Resident #42's Annual MDS assessment dated [DATE], reflected that Resident #42 had a BIMS score of 10 which reflected the resident was moderately cognitively impaired. Resident #42's Annual MDS assessment reflected that the resident was not receiving antiplatelet medication but was receiving anticoagulant medication. Record review of Resident #42's Physician's Orders, dated 12/17/24, reflected the resident had an order for aspirin [OTC] tablet, chewable; 81 mg; amt: 1 tablet (81MG) daily; oral Once A Day. The Physician orders did not reflect an order for an anticoagulant medication. Aspirin is an antiplatelet drug. Record review of Resident #42's care plan dated 10/31/24 reflected Resident #42 was currently taking antiplatelet medication. Goal: resident will receive therapeutic treatment from medication with no complications. Interventions included: Antiplatelet Drug - Monitor for Extreme tiredness, (fatigue), Heartburn, Headache, Upset stomach and nausea, Stomach pain, Diarrhea, Nosebleed. Licensed Nurse will obtain and monitor lab results and report to physician. Record review of Resident #57's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included: anxiety (intense, excessive, and persistent worry and fear about everyday situations), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), atrial fibrillation (a common heart arrhythmia that causes the upper chambers of the heart to beat irregularly and often rapidly), and hyperlipidemia (abnormally high levels of any or all fat cells in the blood). Record review of Resident #57's Admission MDS assessment dated [DATE], reflected that Resident #57 had a BIMS score of 04 which reflected the resident was severely cognitively impaired. Resident #57's Admission MDS assessment reflected that the resident was not receiving antiplatelet medication but was receiving anticoagulant medication. Record review of Resident #57's Physician's Orders, dated 12/17/24, reflected the resident had an order for aspirin [OTC] tablet, chewable; 81 mg; amt: 81mg; oral Once A Day. The Physician orders did not reflect an order for an anticoagulant medication. Aspirin is an antiplatelet drug. Record review of Resident #57's care plan dated 12/16/24 reflected Resident #57's antiplatelet medication was not care planned. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/18/24 at 11:39 AM, the MDS stated she was responsible for completing the MDS assessments. She stated it was the responsibility of the group to check for accuracy of the MDS assessments. She stated she had been trained on completion of MDS assessments and she had been doing this a long time. She stated resident information such as aspirin/antiplatelets, anticoagulants, and hospice should all be reflected correctly on the residents' MDS assessments. She stated if an MDS assessment was not completed correctly, she would have done a modification of the assessment, and it could have caused financial interruption or discretion for the facility. In an interview on 12/18/24 at 01:27 PM, the DON stated the MDS nurse was responsible for completing the MDS assessments. She stated it was the responsibility of the MDS nurse and corporate to check for accuracy of the MDS assessments. She stated the staff responsible for the MDS's had been trained on completion of MDS assessments. She stated resident information such as aspirin/antiplatelets, anticoagulants, and hospice should all be reflected correctly on the residents' MDS assessments. She stated if an MDS assessment was not completed correctly, it would require a modification and could cause the facility to lose money. Record review of RAI Manual MDS 3;0 Section N reflected N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). N0415I2. Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). Record review of the facility's policy dated 2023 with a completed revision date of 05/05/23 and an e-mail revision date of 09/28/23 titled Minimum Data Set reflected Policy: A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident, using the RAI process. Facility staff complete a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences, and offer guidance for further assessment once problems have been identified. Procedures: 1. Review the resident's medical record. This review may include pre-admission activities. Identify resident's status, care and services rendered during the Observation Period for the current assessment. Review is to include, but not be limited to pre-admission, admission, and transfer notes; current plan of care, physicians' orders, progress notes, history and physical; nursing, dietary, activity, social service, and therapy notes and assessments; monthly summaries, lab and x ray reports, consultations, medication administration records, treatment administration records, and resident, staff and family interviews. 2. If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Supplemental information must be gathered and analyzed by the facility based on the triggered CAAs prior to developing the comprehensive care plan. Documentation of the facility's rationale for deciding whether or not to proceed with care planning for each area triggered is recorded in the medical record. The Facility addresses all risks identified within the context of the MOS assessment, even if they do not cause a CAA to trigger. 7. Interview the resident's physician. Ask about the discharge plan, goals of care, medication, and treatment orders. Discuss any negative outcomes identified during assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observation, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 4 of 6 residents (Residents #10, #12, #39, and #57) reviewed for care plans. The facility failed to include anticoagulant medication in Resident #10 and #39's comprehensive care plan. The facility failed to include opioid medication in Resident #12's comprehensive care plan. The facility failed to include antiplatelet medication in Resident #57's comprehensive care plan. This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met. Findings included: Record review of Resident #10's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included: cerebral infarction (a pathologic process that results in an area of dead tissue in the brain), dysphagia (difficulty in swallowing), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). Record review of Resident #10's Quarterly MDS assessment dated [DATE], reflected that Resident #10 had a BIMS score of 00 which reflected the resident was severely cognitively impaired. Resident #10's Quarterly MDS assessment reflected that the resident was receiving anticoagulant medication. Record review of Resident #10's Physician's Orders, dated 12/18/24, reflected the resident had an order for: Eliquis (apixaban) tablet; 5 mg; amt: 1 tablet (5MG) BID; oral Twice A Day on 12/16/24. Eliquis is an anticoagulant medication. Record review of care plan dated 11/13/2024 reflected Resident #10 was not care planned for taking an anticoagulant medication. In an observation on 12/16/24 at 09:35 AM, Resident #10 was laying in her bed. She did not respond when her named was called or when eye contact was given. She continued to be look at the TV with a blank stare. No visible bruising was seen on Resident #10. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included: diffuse traumatic brain injury with loss of consciousness (when a sudden external physical assault damages the brain and involves a loss of consciousness that lasts more than 6 hours), dysphagia (difficulty in swallowing), dysuria (difficult or painful urination), congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), respiratory failure (results from inadequate gas exchange by the respiratory system meaning that the arterial oxygen, carbon dioxide, or both cannot be kept at normal levels), and pain in leg (pain). Record review of Resident #12's Quarterly MDS assessment dated [DATE], reflected that Resident #12 had a BIMS score of 15 which reflected the resident was cognitively intact. Resident #12's Quarterly MDS assessment reflected that the resident was receiving an opioid medication. Record review of Resident #12's Physician's Orders, dated 12/18/24, reflected the resident had an order for: acetaminophen-codeine - Schedule III tablet; 300-30 mg; amt: 1; oral. Special Instructions: 1 tablet PO every 6 hours as needed for pain ordered on 01/26/24 and Tylenol (acetaminophen) [OTC] tablet; 325 mg; amt: 2 tabs; oral Special Instructions: Give 2 tabs PO PRN every 4hrs for mild pain ordered on 11/16/23. Acetaminophen-Codeine is an opioid medication. Record review of Resident #12's care plan which was last revised 10/31/24 reflected Resident #12 was not care planned for taking an opioid medication. In an interview on 12/16/24 at 10:53 AM, Resident #12 stated he was fine, and everything was ok. He stated he had no concerns. Record review of Resident #39's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included: cerebral infarction (a pathologic process that results in an area of dead tissue in the brain), anxiety (intense, excessive, and persistent worry and fear about everyday situations), hyperlipidemia (abnormally high levels of any or all fat cells in the blood), and dysphagia (difficulty in swallowing). Record review of Resident #39's Quarterly MDS assessment dated [DATE], reflected that Resident #39 had a BIMS score of 07 which reflected the resident was severely cognitively impaired. Resident #39's Quarterly MDS assessment reflected that the resident was receiving an anticoagulant medication. Record review of Resident #39's Physician's Orders, dated 12/18/24, reflected the resident had an order for: Eliquis (apixaban) tablet; 5 mg; amt: 1 tab; oral Twice A Day on 08/06/24. Eliquis is an anticoagulant medication. Record review of Resident #39's care plan which was last reviewed 11/18/24 reflected Resident #39 was not care planned for taking an anticoagulant medication. In an interview on 12/16/24 at 10:14 AM, Resident #39 stated things were ok, and she had no concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #57's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included: anxiety (intense, excessive, and persistent worry and fear about everyday situations), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), atrial fibrillation (a common heart arrhythmia that causes the upper chambers of the heart to beat irregularly and often rapidly), and hyperlipidemia (abnormally high levels of any or all fat cells in the blood). Record review of Resident #57's Admission MDS assessment dated [DATE], reflected that Resident #57 had a BIMS score of 04 which reflected the resident was severely cognitively impaired. Record review of Resident #57's Physician's Orders, dated 12/17/24, reflected the resident had an order for aspirin [OTC] tablet, chewable; 81 mg; amt: 81mg; oral Once A Day. Aspirin in an anticoagulant medication. Record review of Resident #57's care plan dated 12/16/24 reflected Resident #57 was not care planned for taking an antiplatelet medication. In an interview on 12/16/24 at 10:10 AM, Resident #57 stated he was fine, and he had no concerns. In an interview on 12/17/24 at 2:04 PM LVN C stated she was an agency nurse and she had worked at the facility for only three days. She stated she was given a 206-page document to read when she started. She stated the MAs passed the medication on the 300 hall, and they should have monitored and documented on the MAR that they monitored for signs and symptoms from anticoagulants. She stated some of the symptoms could have been bruising or bleeding. She stated, she was not sure how the facility monitored anticoagulants on care plans or why Resident #10's care plan did not show anticoagulants. She stated anticoagulant medications should have been included on the care plan and that was a question management should have answered. In an interview on 12/18/24 at 9:11 AM, the DON, stated she had noticed Resident #10's anticoagulant, Eliquis, was not on her care plan but was in her physician's order and being monitored. She stated some nurses knew how to update care plans and some do not. She further stated the MDS coordinator was responsible for ensuring care plans were completed; however, DON, ADON, and LVNs can make changes if a resident received a new order or if there was a change of condition, the care plan would need to be updated. She stated she was responsible for training the LVNs on care plans and if they had any issues with an update, she was available for them to ask for help. She stated she believed they had a care plan policy, and she would have to look for it. She stated negative effects of not monitoring Resident #10's anticoagulant in her care plan would be potential bruising and bleeding, and because she cannot verbally tell staff if she fell or bumped her elbow, which could lead to a bruise, staff would not know to monitor for bruising. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/18/24 at 9:20 AM, the MDS stated depending on the department, such as social services were responsible for care planning and monitoring behaviors, anti -psychotic drugs, and anticoagulant medications, would determine who was responsible for documenting on the care plan, but she was responsible for the initial care plan unless there was a change and/ or medication started after the comprehensive assessment was done. She stated the DON was good at keeping up with the care plans however she could not believe Resident #10 had been at the facility for 3 years and no one had noticed her anticoagulant was not on her care plan. She stated as of 12/18/24 she was starting a care plan audit. She stated she did not look at a care plans when most important was a residents lab work and the Nurse Practitioner's concerns. A care plan was not going to decide on a resident care like the labs and the Doctor who would provide information such as blood in the stool, vomiting, and falls. In an interview on 12/18/24 at 11:39 AM, the MDS stated she was responsible for completing the MDS assessments. She stated it was a group of staff, such as the DON, Dietary Manager, Social Services, and Charge Nurses who were responsible for completing care plans. She stated it was the responsibility of the group to check for accuracy of the care plans. She stated she had been trained on completion of care plans and she had been doing this a long time. She stated resident information such as aspirin/antiplatelets, anticoagulants, and pain should have all been reflected correctly on the care plans. She stated if a resident's care plan was completed inaccurately, it could have caused confusion towards staff regarding the resident's care. In an interview on 12/18/24 at 01:27 PM, the DON stated there are multiple staff members, such as herself, activities, nurse leadership, charge nurses, social services, and dietary manager that were responsible for completing care plans. She stated it was the responsibility of the MDS nurse and corporate to check for accuracy of the care plans. She stated the staff responsible for the care plans had been trained on completion of care plans. She stated resident information such as aspirin/antiplatelets, anticoagulants, and pain should have all been reflected correctly on the care plans. She stated if a resident's care plan was completed inaccurately, she does not really know how it would affect the resident because there are orders in place to monitor for pain and for any bleeding due to the anticoagulants/antiplatelets and as long as the staff were following physicians orders, the resident should not have been affected. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy dated 2023 (complete revision May 5, 2023) titled Care Plan Process, Person-Centered Care revealed Policy: The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes trying to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and understanding the resident's life before coming to reside in the nursing home . The services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, will meet professional standards of quality. Procedures: 2.The baseline person-centered care plan will include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, resident goals, physician orders, dietary orders, therapy services, social services, and PASRR recommendation, if applicable. 3.Following RAI Guidelines develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 4. A. The Baseline Person-centered care plan Summary includes immediate resident needs. B. Physician Orders or CCD (Continuity of Care Document). 9. Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates the need such as but not limited to falls and pressure ulcer development. 11. The person-centered care plan includes: A. Date B. Problem C. Resident goals for admission and desired outcomes D. Time frames for achievement E. Interventions, discipline specific services, and frequency F. Refusal of services and/or treatments 1) Evaluation of resident's decision-making capacity 2) Educational attempts 3) Attempts to find alternative means to address the identified risk/need. G. Discharge plans 1) Resident's preference and potential for future discharge 2) Resident's desire to return to the community and any referrals to local contact agencies and/or other appropriate entities, for this purpose. H. Resolution/Goal Analysis

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observations, interview, and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 4 of 6 residents (Resident #3, Resident #37, Resident #41, and Resident #52) reviewed for hygiene. The facility failed to ensure Resident #3 Resident #37, Resident #41, Resident #52 received a shower or bath as scheduled. This deficient practice could place residents who were dependent on staff for ADL care at risk for loss of dignity, and/or a diminished quality of life. The findings were: Resident #3 Record review of Resident #3's undated face sheet reflected she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Paraplegia (the inability to move the lower half of the body), unspecified, Cerebral infarction (a condition in which part of the brain dies from lack of oxygen), unspecified, Neuromuscular dysfunction of bladder (when the nerves and muscles that control your bladder are not working), unspecified, and Muscle wasting and atrophy. Record review of Resident #3's care plan dated 08/20/2024 reflected Resident #3 required assistance with ADLs. The care plan's goal was that Resident #3 would maintain a sense of dignity by being clean, dry, odor free and well-groomed over the next 90 days. Interventions included: Bathing- Assist of 1 or 2 staff members- If showering, use 2 staff and the mechanical lift. Encourage resident to take a shower, she often refuses and only wants a bed bath. Sometimes she refuses the bed bath. Record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 15 indicating she was cognitively intact. The MDS reflected she was Dependent for bathing indicating the helper does all the effort and the resident does none of the effort to complete the activity. The MDS reflected the resident did not reject care. Record review of an undated facility shower assignment sheet reflected Resident #3 was to receive a shower or bed bath every Monday, Wednesday, and Friday on the day shift. The schedule indicated resident should have received a shower or bed bath on 12/2, 12/4, 12/6, 12/9, 12/11, 12/13, 12/16, 12/18. Record review of the resident shower assignment sheet for 12/02/24 reflected that Resident #3 had received a bed bath on 12/2/24, the Resident left early for an appointment and was not bathed. Date of 12/4/24 and was not showered with no indication resident had refused care. On dates of 12/9/24, 12/11/24, and 12/13/24 the shower assignment sheet was signed by a CNA but was not marked for bed bath or shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Point of care history report for the month of December 2024 reflected Resident #3 received Physical help with bathing on 12/02/24, Bathing activity did not occur on 12/4/24, total dependence (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for 12/6/24, supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) on 12/9/24 , activity did not occur on 12/11/24, activity did not occur on 12/13/24, activity did not occur on 12/16/24. In an interview and observation on 12/16/24 at 10:10 AM Resident #3 stated she was to have surgery on her right eye today and would like a bath prior to surgery. She stated the staff said they would come but have not. Resident #3 was worried about being on time and stated she had to leave at 11:30 am. Resident #3 had a urine odor to her clothing and her sheets had food spills on them from her breakfast . In an interview on 12/17/24 at 1:53 PM, Resident #3 stated she did not get a shower yesterday prior to her appointment. Resident #3 stated she just did not want to stink prior to her appointment. She stated she was unsure the day of her last shower. Resident #37 Record review of Resident #37's undated face sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Chronic obstructive pulmonary disease (a condition of the lungs affecting the ability to breathe), unspecified, Type 2 diabetes mellitus without complications (elevated blood sugars), Rash and other nonspecific skin eruption, and Muscle weakness. Record review of Resident #37's care plan dated 08/20/2024 reflected Resident #37 required assistance with ADLs. The care plan's goal was that Resident #37 would maintain a sense of dignity by being clean, dry, odor free and well-groomed over the next 90 days. Interventions included: Bathing Assist of 1- often refuses related to his breathing. Resident #37 preferred to shower only 1 time weekly, and staff will honor his wishes. Record review of Resident #37's Quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 11 indicating he had moderate cognitive impairment. The MDS reflected he required substantial/maximal assistance with bathing indicating the helper does more than half the effort to complete the task. The MDS reflected the resident did not reject care. Record review of an undated facility shower assignment sheet reflected Resident #37 was to receive a shower every Tuesday, Thursday, and Saturday on the day shift. The schedule indicated resident should have received a shower or bed bath on 12/3/24, 12/5/24, 12/7/24, 12/10/24, 12/12/24, 12/14/24, 12/17/24. Record review of Point of care history report for the month of December 2024 reflected shower activity did not occur from December 03/2024 to December 17/2024 indicating Resident #37 missed 7 opportunities for showering equaling 14 days without a shower. Record review of facility progress notes for 12/1/2024 to 12/17/2024 did not indicated Resident #37 had refused his showers. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 12/16/24 at 9:54 AM Resident #37 stated he hasn't had a shower in a while, sometime last week. He has musty body odor, and his clothes are disheveled and appear dirty . Resident #37 stated he used to have a schedule for his showers on his wall and he can't remember what days. Resident #37 said he would like to have a shower consistently. Resident #41 Record review of Resident #41's undated face sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Cerebral infarction, unspecified (a condition in which part of the brain dies from lack of oxygen), Type 2 diabetes mellitus (elevated blood sugars), Iron deficiency anemia, and Major depressive disorder, recurrent. Record review of care plan dated 12/28/2022 reflected Resident #41 required assistance with ADLs. He will refuse to take shower and will. refuse to get out of bed. The care plan's goal was that Resident #41 would maintain a sense of dignity by being clean, dry, odor free and well-groomed over the next 90 days. Interventions included: BATHING: Assist of 1 if giving a bed bath, requires 2 staff members when giving a shower. Record review of Resident #41's Annual MDS assessment dated [DATE] reflected he had a BIMS score of 13 indicating he was cognitively intact. The MDS reflected he was Dependent for bathing indicating the helper does all the effort and the resident does none of the effort to complete the activity. The MDS reflected the resident did not reject care. Record review of Progress notes dated 12/1/24 to 12/17/24 reflected no episodes of Resident #41 refusing his showers. Record review of an undated facility shower assignment sheet reflected Resident #41 was to receive a shower every Tuesday Thursday and Saturday on the day shift. The schedule indicated resident should have received a shower or bed bath on 12/3, 12/5, 12/7, 12/10, 12/12, 12/14, 12/17. Record review of Point of care history report for the month of December 2024 reflected shower activity occurred on 12/10/24 and a bed bath was given on 12/17/24. This indicated that Resident #41 was bathed 2 times within the last 17 days. In an interview on 12/16/24 at 10:01 AM Resident #41 stated he hasn't had a shower in many days. He stated he would like to, but the staff must use a mechanical lift and that is just too difficult. Resident #41 stated he would like to feel clean, Resident #52 Record review of Resident #52's undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Unspecified fracture of left femur, initial encounter for closed fracture, Polyosteoarthritis (arthritis in multiple joints), Pediatric feeding disorder, Muscle weakness, Dysphagia (difficulty swallowing), seizures, and Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side (paralysis after a stroke). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52's care plan dated 11/06/2024 reflected Resident #52 required assistance with ADLs. The care plan's goal was that Resident #52 would maintain a sense of dignity by being clean, dry, odor free and well-groomed over the next 90 days. Interventions included: BATHING: Assist of 1 if giving a bed bath, requires 2 staff members when giving a shower. Record review of Resident #52's Quarterly MDS assessment dated [DATE] reflected she had severely impaired cognition and was unable to complete the BIMS. The MDS reflected she was Dependent for bathing indicating the helper does all the effort and the resident does none of the effort to complete the activity. The MDS reflected the resident did not reject care. Record review of an undated facility shower assignment sheet reflected Resident #52 was to receive a shower every Monday, Wednesday, and Friday on the day shift. The schedule indicated Resident #52 should have received a shower or bed bath on 12/2/24, 12/4/24, 12/6/24, 12/9/24, 12/11/24, 12/13/24, and 12/16/24. Record review of Point of care history report for the month of December 2024 reflected shower activity occurred on 12/02/24 and a bed bath was given on 12/04/24 and 12/11/24. This indicated that Resident #52 was only bathed 3 times within the last 17 days. In an interview on 12/16/24 at 11:42 AM with Resident #52's family member and guardian stated it had been 1 week since Resident #52 had been showered, the staff just do not shower her unless I'm on them . The Family Member stated Resident #52 does not have the capability to refuse care as she is nonverbal. In an interview on 12/17/24 at 2:10 PM CNA H stated she was not at the facility all the time and works for an agency. She stated she feels like the facility is adequately staffed to meet resident's needs. She stated documentation of showers is completed in the residents plan of care She stated the facility also has a handout that the nurse aides acquire at the start of their shifts with resident room numbers and beds assigned to shower days. She stated if a resident were to refuse their shower the staff report that to the charge nurse and the charge nurse then reports to the DON. CNA H was not aware of Residents #3, #37, #41, and #52's showers had been missed or refused. She stated negative effects for not giving showers could include body odors and depression. In an interview on 12/17/24 at 2:17 PM with MA G she stated she works for an agency and floats the building depending on where they need her to work. She stated she had been trained on ADL policy and care required to provide. She stated shower documentation was completed within the POC under bathing. She stated there was a shower sheet completed also that was handed in to the nurse. She stated the facility was not always adequately staffed to give the showers. She stated occasionally residents refuse their showers and at that time she would leave the resident and attempt again later in the day. MA G stated if a resident were to refuse a second time, she would notify the charge nurse and mark the shower as refused. MA G stated some of the negative effects for not giving showers would be body odors, depression, and skin irritation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/18/24 at 9:25am LVN B stated the CNAs should report to the nurses and then the nurse will attempt to convince the resident to take a shower. She stated there was a shower sheet and if the resident refused the shower the nurse will fill out a sheet and sign it and send the sheet to the DON informing her of the refusal. LVN B stated there were some residents who do refuse showers often and some of the residents only like certain staff. LVN B stated she had suggested getting a shower aide to the DON because It's hard to keep up with the call lights sometimes when the CNAs are in the rooms giving showers. She stated negative effects for not giving showers could include poor hygiene and depression. She stated residents feel better when they are showered. In an interview on 12/18/24 at 01:27 PM The DON stated her expectations are that the shower is due the day it is due. She stated staff need to find out why the resident is not taking their shower. The DON stated all staff were trained when they enter the facility on ADL care. She stated the facility will also pair agency staff with another CNA who will train them. She stated the charge nurse was responsible for charting interventions and communication with the management when residents refuse showers. She stated staff needed to alert families and DON of problems, so families are not shocked when they discover their loved one is refusing showers. The DON stated negative effects on the resident really depends on the person. She said some of these residents did not bathe 3 times a week at home and we must honor their rights when they refuse the shower. Record review of facility policy titled Activities of Daily Living, Optimal Function dated May 05, 2023, reflected The facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interview, and record review, the facility failed to ensure residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and a resident with pressure ulcers receives the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 3 (Resident #3, Resident #41, and Resident #52) of 6 residents reviewed for quality of care. The facility failed to complete weekly skin assessments according to their orders and for Residents # 3, # 41, and # 52. These failures could place residents at risk for developing pressure ulcers or wounds. Findings included: Resident #3 Record review of Resident #3's undated face sheet reflected she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Paraplegia (the inability to move the lower half of the body), unspecified, Cerebral infarction (a condition in which part of the brain dies from lack of oxygen), unspecified, Neuromuscular dysfunction of bladder (when the nerves and muscles that control your bladder are not working), unspecified, and Muscle wasting and atrophy. Record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 15 indicating she was cognitively intact. The MDS reflected Resident #3 was at risk for pressure ulcer /injuries The MDS reflected she was admitted with a stage 3 pressure ulcer. Record review of Resident #3's care plan dated 08/20/2024 reflected Resident #3 has a Stage 3 Pressure ulcer to Coccyx (buttocks). Resident goal was that Resident's skin will remain intact. Interventions included to Report any signs of skin breakdown (sore, tender, red, or broken areas). Record review of an undated physicians order report reflected Resident #3 was ordered to have a skin inspection completed weekly on Fridays with a start dated on 03/27/2024. Record review of observation history report for the month of December 2024 reflected Resident #3 had no weekly skin observation from 12/01/2024 to 12/17/2024. Resident #41 Record review of Resident #41's undated face sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Cerebral infarction, unspecified (a condition in which part of the brain dies from lack of oxygen), Type 2 diabetes mellitus (elevated blood sugars), Iron deficiency anemia, and Major depressive disorder, recurrent. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's Annual MDS assessment dated [DATE] reflected he had a BIMS score of 13 indicating he was cognitively intact. The MDS reflected Resident #41 was at risk for pressure ulcer /injuries. The MDS reflected Resident #41 had a venous and arterial ulcer present. Record review of care plan dated 12/28/2022 reflected Resident #41 is at risk for pressure ulcers related to debility, moisture, current and HX of pressure ulcers. Resident #41's goal was for skin to remain intact. Interventions on the care plan included to conduct a systematic skin inspection weekly, pay particular attention to the bony prominences. Record review of undated physicians order report reflected Resident #41 was ordered to have a skin inspection completed weekly on Fridays with a start dated on 03/27/2024. Record review of observation history report for the month of December 2024 reflected Resident #41 had no weekly skin observation from 12/01/2024 to 12/17/2024. Resident #52 Record review of Resident #52's undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Unspecified fracture of left femur, initial encounter for closed fracture, Polyosteoarthritis (arthritis in multiple joints), Pediatric feeding disorder, Muscle weakness, Dysphagia (difficulty swallowing) seizures, and Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side (paralysis after a stroke). Record review of Resident #52's Quarterly MDS assessment dated [DATE] reflected she had severely impaired cognition and was unable to complete the BIMS. The MDS reflected she was Dependent for bathing indicating the helper does all the effort and the resident does none of the effort to complete the activity. The MDS reflected Resident #52 was at risk for pressure ulcer /injuries. The MDS reflected Resident #52 had no current pressure ulcers or skin injuries. Record review of Resident #52's care plan dated 03/20/2024 reflected Resident #52 was at risk for pressure ulcers related to moisture, debility, decreased sensory perception. The residents' goal was for the skin to remain intact. Interventions included Report any signs of skin breakdown (sore, tender, red, or broken areas). Record review of an undated physicians order report reflected Resident #52 was ordered to have a skin inspection completed weekly on Wednesday with a start date on 10/18/2024. Record review of observation history report for the month of December 2024 reflected Resident #52 had one weekly skin inspection dated 12/04/2024 from 12/01/2024 to 12/17/2024. In an interview on 12/18/24 at 9:25am LVN B stated the nurses were responsible for completing the skin assessments for the residents. She stated skin assessments were ordered for A bed on the morning shift and B bed were on the night shift once weekly. She stated skin assessments were documented under observations within the medical record. She stated she was not sure why Residents #3, #41, or #52's skin assessments were not completed. LVN B stated failure to complete weekly skin assessments could lead to pressure sores or skin issues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/18/24 at 1:27 PM The DON stated she has to hold the nurses accountable, and her expectations were that skin assessments were to be completed on the day they are due. She stated there was an order in the computer for them to be completed that alerts the nurse on treatment record to complete the skin assessments. She stated the nurses were trained on the skin assessment and skin system as needed, quarterly, and monthly at the all-staff meeting. She stated the wound care nurse, and The DON were responsible for ensuring skin assessments were completed. She stated she was not sure why Residents #3, #41, or #52's skin assessments were not completed. She stated the facility has been relying on agency nurses to staff their building and its difficult to follow up with them to ensure their work was completed. The DON stated negative effects for residents when not completing skin assessments included not catching skin issues early that can lead to worsening outcomes for residents. In an interview on 12/18/24 at 2:01 PM LVN D stated she has worked at the facility for 1 month. She stated, skin assessments were the responsibility of the nurses. She stated she and The DON oversee the system to make sure the skin assessments were completed. She stated the facility had had a lot of agency nurses in the building and that is the reason why the skin assessments were not completed. She stated she was not sure why Residents #3, #41, or #52's skin assessments has not been completed. She stated negative effects for not completing skin assessments included skin breakdown and worsening skin issues. Record review of facility policy titled Documentation -Licensed Nursing dated May 5, 2023, reflected Documentation pertaining to the patient/resident will be recorded in accordance with regulatory guidelines. The nursing staff will be responsible for recording care and treatment observations and assessments and other appropriate entries in the patient /resident clinical record. Surveyor requested skin assessment policy on 12/18/24 and it was not provided by facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001 Based on observation, interview, and record review the facility failed to label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 5 medication carts reviewed in that: The medication cart for the 100 hall, 200 hall and 300 halls had thirteen unidentified loose pills and a personal purse was stored in the bottom drawer of medication cart for the 200 and half of 300 hall. These deficient practices could affect residents and result in a drug diversion due to medications not being properly disposed and secured. The findings were: Observation of medication cart for the 200 hall and half of the 300 halls on [DATE] at 08:50 am revealed one big round white pill with L403: on one side and 325MG on the other side, one big oval white pill with ATV 40 on one side and blank on the other side. One small round white pill with the letters HH on one side and the numbers 223 on the other side. One small round white pill with the letter G on one side and the number 41 on the other side. One big white round pill with the number 209 on one side and blank on the other side. One small yellow round pill with the letter T on one side and blank on the other side. One round small white pill with N029 on one side and blank on the other side and one round white pill with TEVA on one side and the other side had the number 54. MA E was not able to identify the eight loose pills. Observation of medication cart for the 100 hall and half of the 300 halls on [DATE] at 09:40 am revealed one big round white pill with the number 209 on one side and blank on the other side. One pink small round pill with LUPIN on one side and the number 10 on the other side. One small white round pill with the letters WW on one side and the number 771 on the other side. One small pink oval pill with the letter 5 on one side and the number 894 on the other side. One small white round pill with the number 144 on one side and the letters W/W on the other side. MA F was not able to identify the five loose pills. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MA E on [DATE] at 09:27 am voiced when she notices loose pills in the bottom of the cart, she disposes of them. She verbalized she would dispose of the eight pills that were found in the bottom of her cart today in the biohazard dispenser. MA E voiced that a resident would have to get a key in order to get into the medication cart. Therefore, she wouldn't normally see staff take it or anything. They would just normally dispose of it. MA E verbalized a lot of times if too many blister packs are in the medication cart, they all get compacted and they can go through the ones pushed in the back and the pills will pop out. MA E verbalized routine checks of the blister packs is what can prevent that from happening. MA E voiced if she saw pills on the bottom of the medication cart she would use a pill identifier to see what kind of pill it is and then put it in the trash. MA E voiced loose pills was not included in the new hire training, but they've been instructed before from bosses and staff and just training over time to dispose of loose pills. Interview with MA F on [DATE] at 10:02 am verbalized it is not okay to keep personal items including purses in the medication carts. The adverse effects of having personal property stored inside a medication cart can be cross contamination, it can be harmful, it can cause confusion or be a distraction while working. MA F voiced staff get in-serviced on medication carts, monthly. She is not sure about a policy for storing personal items on the medication cart and if there is one MA F stated she is not sure what it states specifically. MA F voiced she has not seen loose pills in the medication carts. If she did see any loose pills, she would dispose of them. MA F was not sure if there is a policy for loose pills in carts, but verbalized staff has been told about loose pills in the past. MA F acknowledged she was trained on loose pills when she was hired in November. MA F voiced that the pills may have fallen to the bottom of the medication cart when they are being popped out of their blister packs and staff just don't notice. Interview with LVN A on [DATE] at 10:15 am voiced it is not okay to store personal items on the medication carts. The adverse effects of having personal property stored inside a medication cart can be that if a staff member has a drink or anything like that it can spill on medications. If it were a purse being stored on or inside the cart, would be sketchy (dishonest) as far as might be putting medications in your purse. LVN A voiced that staff get in-serviced on medication carts and they just had this one this week besides that she thought it had been a month or two. LVN A voiced staff have been trained on not keeping personal items on medication carts. LVN A verbalized staff are not allowed to have personal belongings, they are instructed to keep personal belongings at the nurse's station. She did not give an answer when asked if she knew of any policy the facility may have related to personal items on the carts. LVN A stated she has seen loose pills in the bottom of the medication cart under the blister packets that hold the medications. She usually disposes of them when she does see them and there is a policy for loose pills. She voiced she has been trained on the policy for loose pills. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:24 AM, MA G stated it is not okay to store personal items on the carts. MA G said if a personal purse is stored in the bottom of the medication cart where resident medications are stored, people may be able to steal medications or medications may fall into the purse. The liquid medication may spill into the purse. MA G acknowledged that staff are trained at least once a month over medication carts. MA G was not sure if there was a specific policy related to storing personal items in the medication carts but staff have been told multiple times not to store personal property on or inside the carts. MA G stated sometimes she has seen loose pills in the bottom of the medication carts. If she sees loose pills, she notifies the nurse and if the nurse is busy she notifies the DON. Loose pills are disposed in the sharp's container. MA G stated she has not been trained on loose pills. MA G stated she thinks the pills may come loose and fall to the bottom of the medication carts because when staff are dispensing the medications into the medication cups, the medication may fall sometimes. When that happens to her, she looks for the medication and tells the nurse and it is disposed. MA G stated that all MAs are responsible for cleaning the carts and she usually does it in between medication passes. During an interview on [DATE] at 10:31 AM, LVN B stated that it is not okay for personal items to be stored in the medication carts, including purses. LVN B added we technically have lockers. LVN B stated some potential adverse effects of having personal items such as a purse stored in the medication cart, could be that the purse could get stolen. Residents can get into the purse depending on what is in it. LVN B stated that staff go over in-services that educated it is better practice not to have drinks and personal property on carts. LVN B stated she has not really seen loose pills in the bottom of the medication carts under the blister packets. If she were to see any loose pills, she would dispose of them in the sharp's container. LVN B stated that as far as a policy for loose pills staff are supposed to maintain clean carts and she knows if a narcotic is found on the bottom of a cart or falls inside the cart, staff should get a second person to observe the disposing of the medication in the sharps container. LVN B stated there has probably been an in-service for loose pills. Staff are in-serviced and there is a book that shows all in-services. LVN B stated all nurses and MAs are responsible for cleaning out the carts. A lot of times night shift have more time, but day shift will need to clean them too. LVN B stated that the loose pills may have come loose and fell to the bottom of the medication cart because sometimes when they are dispensing the medication into the small cup from the blister packets it can fall. If it falls staff are supposed to try to find it and tell the nurse so it can be chunked . During an interview on [DATE] at 10:38 AM, DON stated it is not okay for staff to store personal items such as a personal purse inside the medication carts. Some harmful things that could happen if staff have personal items on the carts is that they don't know what they're bringing from their homes. There is potential for theft of medications and supplies from the carts. DON stated she thinks the facility has done a lot of in-services on storing personal items on carts. She has never found any personal items inside of the carts. DON was not sure if there is a policy on storing personal property on medication carts. DON stated it is not normal for loose medication pills to be on the bottom of the medication carts. All staff are responsible for cleaning and checking the carts. DON stated they do a monthly audit to look for those things including expired dates. DON was unsure if there was a facility policy that covered loose pills. DON voiced staff are trained on loose pills when they do their monthly audits on carts. DON stated she thinks the pills come out of the blister packets and fall to the bottom of the medication carts because the carts are so full of blister packets. The backs are so thin that pills pop out easily. (continued on next page)

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	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Brazos of Waco	2430 Market Place Drive Waco, TX 76711

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Facility's Medication Management Program states: Policy - The facility implements a medication management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements. Procedures: Administering the medication pass - #16 states: once removed from the package or container, unused doses should be destroyed following facility policy and documenting the destruction according to facility policy.