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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Chateau 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation. The facility failed to properly discard dented/damaged cans and take them out of use for resident consumption. This failure could place residents at risk of foodborne contamination.Findings included: In an interview and observation on 03/17/2026 at 9:19 AM, with [NAME] A, she stated that she had just returned to work on 03/16/2026 from extended leave. She stated the previous DM was no longer employed at the facility upon her return. When the surveyor asked where the dented cans were kept, [NAME] A pointed to a large array of cans, sitting on a lower shelf under the food preparation table, some with visible dents. She stated that the previous DM had instructed the cooks to use the dented cans first, and the cans were not sent back with the supplier or discarded.In an interview on 03/17/2026 at 12:45 PM, with [NAME] B, she stated she had not been working at the facility for long. She stated that the dented cans kept on the lower shelf beneath the preparation table, were what the previous DM told the cooks to separate from regular cans, and to use those dented cans first for cooking. [NAME] B stated she had finished her computer-based training recently and that training also told her to use dented cans first. She stated that she did not, however, use the dented cans because she knew she was supposed to use undamaged cans to cook with. In an interview on 03/17/2026 at 12:48 PM with the SFDM, she stated that the facility practice should be to put dented/damaged cans in the DM's office, and/or dump them out, and they were not to be used for resident meals. She stated that dented cans should not be used because metal shavings could get in resident's food. She stated she was not sure how long the previous DM was working at the facility or how long the practice of using the dented cans was in place for. She also stated that she was positive the computer-based training did not instruct cooks to use dented cans at all. The SFDM stated that the kitchen followed guidance from the TFER and FDA food code.In an interview on 03/19/2026 at 12:39 PM with the ADM and DON revealed that they were not aware the previous DM had told the cooks to use dented cans. They stated the process for dented cans was that the staff were supposed to check for dents before the delivery truck unloaded to ensure dent-free cans, and to give damaged cans back or to refuse them. The ADM stated that if the damaged cans made their way into the kitchen, the cans need not be placed on the shelf and not used or given to DM. The ADM stated that there could be holes in the cans, food could be contaminated, or infection could be passed onto the residents. The DON stated that there were 3 residents in the facility who required tube feedings and did not eat from the kitchen. The ADM stated that the kitchen followed the guidance from the TFER and FDA food code.Review of the 2022 FDA food code revealed on page 147, Products that are held by the permit holder for credit, redemption, or return to the distributor, such as damaged, spoiled, or recalled products, shall be segregated and held in designated areas that are separated from food, equipment, utensils, linens, and single-service and single-use articles. On page 346 under ?Compliance with Food Law' revealed, Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard. On Page 359 revealed, Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Suspect cans must be returned .Review of the August 2021 TFER revealed, Food shall be obtained from approved sources in accordance with Food Code, Subpart 3-201, 228.61 of this chapter, and 228.62 of this chapter and shall be in sound condition and be safe for human consumption.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to ensure residents had the right to a dignified existence for 1 of 16 (Resident #39) residents reviewed.The facility failed to treat Resident #39 with dignity and respect when MA F had called her little girl and asked, what is wrong with you?.This failure could place residents at risk for psychosocial harm and isolation.Findings Included:Record review of Resident #39's face sheet revealed a [AGE] year-old woman who admitted to the facility on [DATE], who had diagnoses of chronic obstructive pulmonary disease (a progressive, incurable lung disease), hyperlipidemia (common condition characterized by high levels of lipids), cerebral infarction (a serious medical emergency where blood flow to part of the brain is blocked, causing tissue death due to lack of oxygen) and major depressive disorder (serious, common mood disorder characterized by persistent sadness, loss of interest and low energy lasting at least two weeks).RR of Resident #39's quarterly MDS assessment dated [DATE] revealed that Resident #39 had a BIMS score of 14, which indicated no cognitive impairment. The MDS also revealed that Resident #39 had refused care 1-3 times during the review period.RR of Resident #39's Care Plan dated 01/27/2026 revealed Resident #39 had a diagnosis of depression. The goal indicated Resident #39 will not exhibit signs of isolation. The interventions listed on the care plan indicated staff should convey an attitude of acceptance toward the residents, establish a trusting relationship with the residents, and support the resident's appropriate mood and behaviors.An observation conducted on 03/18/2026 at 10:19AM revealed MA F had entered Resident #39's bedroom and was heard saying Why are you walking around with scissors? What is wrong with you? During the observation, MA F then told Resident #39 to come over here and sit-down little girl in a demeaning way.An interview was attempted on 03/18/2026 at 3:15PM with Resident #39 but was unsuccessful because she was asleep and did not want to talk.An interview was conducted on 03/18/2026 at 3:15PM with Resident #39's husband. Resident #39's RP stated that he and his wife had always had issues with MA F. He stated the issues they had involved in the way MA F communicated with him and Resident #39. He stated that when MA F talked to Resident #39 in the manner she did listed above, it made him feel angry and hurt for his wife.An interview was conducted on 03/19/2026 at 1:56pm with LVN E who stated she had been employed at the facility for a little less than a year. LVN E stated she had received training on resident rights which included the residents had the right to dignity. LVN E also stated she had received training on dignity which included how staff should talk to residents with respect. LVN E stated staff should never call residents by another name, like little girl. She stated that it could affect the residents by the development of depression and isolation. LVN E stated she had not witnessed MA F talk to residents without dignity and respect, but would report it to the AC who was also the ADM.An interview was conducted on 03/19/2026 at 2:53PM with MA G who stated he had been employed at the facility for 4 months. MA G stated he had received training in dignity which included how staff should make residents feel welcome and to ensure that their dignity is upheld. MA G stated that staff should talk to residents with respect at all times and never should be called a nickname, like little girl. MA G stated that residents could refuse to eat and develop depression as a result of not being treated with dignity and respect. MA G stated that if he had suspicions of these concerns, he would report it to the AC who was also the ADM.An interview was conducted on 03/19/2026 at 3:14PM with CNA C who stated she had been employed at the facility for 2 months. CNA C stated she had received training on dignity which included training on how staff are to treat residents and talk to residents with respect. CNA C stated it would never be okay to call a resident by a nickname such as little girl. CNA C stated it could affect the residents to feel sad if they were not treated with dignity and respect. CNA C stated if she had witnessed any concerns of the nature, she would report it to the AC, who was also the ADM.An interview was attempted on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/19/2026 at 3:27PM with MA F but was unsuccessful due to not answering the phone.An interview was conducted on 03/19/2026 at 03:29PM with the DON who stated she had been employed at the facility for a little under a year. The DON stated she had received training on dignity which included residents should received the care they need with autonomy and respect. The DON stated her expectation for floor staff was to be respectful and provide dignified care to all residents. She stated she expected her staff to use respectful verbiage and tone when engaged with residents. The DON stated should staff members call residents by nicknames such as little girl, it would affect the residents' psychosocial wellbeing. She stated she had not been made aware of staff treating residents poorly.An interview was conducted on 03/19/2026 at 03:56PM with the ADM who stated she had been employed at the facility for a little over 1.5 months. The ADM stated she had received training on dignity at the facility. She stated her policy for dignity included that the residents have the right to be dignified and treated with respect. The ADM stated it could negatively affect the residents if staff had talked down on them, by causing residents to not feel safe, upset, and worthless even. She stated she had not had any complaints about staff treating residents poorly.RR of the in-services conducted on 03/19/2026 indicated the facility had not conducted in-service training on dignity for the staff in the last 3 months.RR of the facility provided policy titled Resident Rights Dignity and Respect dated 05/06/2021 revealed the following:It is the policy for this facility that all residents be treated with kindness, dignity and respect.The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings.Violations of the Residents' right to dignity and respect should be promptly reported to the DON and/or the ADM.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #69) observed for infection prevention.The facility failed to ensure Enhanced Barrier Precautions (EBP) were followed when CNA C and CNA D performed catheter and peri care for Resident #69.This deficient practice could place residents at risk for the spread of infection.Findings Included: Record review of Resident #69's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: Type II Diabetes, Vascular dementia (decreased blood flow to areas of your brain), Respiratory disorders and diseases, Hypertension (high blood pressure), Sleep Apnea (common condition where breathing stops and starts again), Uninhibited Neuropathic Bladder (frequent urination, reoccurring urinary tract infections, unable to hold urine often following a stroke in Parkinson's patients, or dementia), transient cerebral ischemic attack (Stroke), Congestive heart failure (long term condition that affects your hearts ability to pump blood well).Record review of Resident#69's physician orders revealed that an order with the start date of 02/23/2026, Enhanced Barrier precautions: PPE required for high resident contact care activities. Indication: Indwelling catheter each shift. This was documented and acknowledged each shift on the Treatment Administration Record by the covering nurses.Record review of care plan initiated on 02/23/2026 revealed that Resident #69 was on EBP and interventions included: Direct care staff to utilize gowns and gloves for all personal care.In observations during the duration of the survey between 3/17/2026 9AM-4:30PM, 03/18/2026 9AM-4:30PM and 3/19/2026 9AM-4:00PM, signs were observed on several resident doors stating, Enhanced Barrier Precautions Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and gown for the following High-Contact Resident Care Activities. Dressing, Bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use central line, urinary catheters, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. Also noted on resident nameplates next to specific residents the initials EBP designating which resident in the room had an order for EBP.In an observation on 03/18/2026 at 10:08 AM of peri and catheter care for Resident #69 performed by CNA C and CNA D revealed staff performed care following aseptic technique cleansing hands and changing gloves at appropriate intervals to prevent the spread of infection. Staff failed to wear gowns in providing this care. No sign on Resident #69's door or name plate was noted indicating she was on EBP. Observed that there was also not a supply of PPE outside the door as noted at most resident doors indicating they were on EBP.In an interview on 03/18/2026 at 10:23AM with CNA C she stated she was frequently in-serviced on infection control, and it included EBP. She stated that she would know a resident was on EBP by the sign on the door and the name plate indication. She stated the nurse would also inform a CNA if a resident was on EBP and it can be seen in the plan of care. She stated if a resident is on EBP they would need to wear a gown and gloves when providing care to a resident to prevent the spread of germs. She stated the IP was responsible for placing the EBP signs on the door and name plate. She stated that she did not wear a gown when providing the care as there was not a sign on the door and she did not think fully about the fact that she had a catheter. She stated that typically residents with catheters and wounds are on EBP. She stated she should have realized the resident should be on EBP.In an interview on 03/18/2026 at 10:25 AM with CNA D she stated she was frequently in-serviced on infection control which included EBP. She stated she would know a resident was on EBP by the sign indicating on the door and the EBP sticker by their name on the name plate. She stated she can also see in PCC. She stated that she was unsure why there was not a sign on Resident #69's door and does not know why it did not dawn on her that catheter care typically means (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident is on EBP. She stated that she did not get a chance to check PCC prior to performing the care that was observed. She stated that residents with wounds and catheters are typically on EBP. She stated the IP is responsible for placing the signs on the door and the stickers next to the name plate indicating a resident is on EBP. She stated if a resident is on EBP they should wear gowns and gloves when performing care to prevent them from carrying bacteria from their clothing to the resident.In an interview on 03/18/2026 at 1:00PM with LVN E she stated she has been a nurse for over 25 years, and she is frequently in-serviced on infection control which covers enhanced barrier precautions. She stated that residents that have wounds, catheters, peg tubes or any device that enters the body would be placed on enhanced barrier precautions. She stated that when a resident is on enhanced barrier precautions the staff providing care should wear a gown and gloves. She stated if the staff do not wear PPE while performing care, they can spread bacteria causing the residents to become sick. She stated, the staff knows a resident is on EBP when there is a sign on the door and a small sticker next to their name plate that states, EBP. She stated that EBP direction can be found in the care plan and in orders. She stated the nurse would also tell the CNA if there was an order for EBP. She stated that the infection preventionist typically places the signs on the door and the sticker on the name plate.In an interview on 03/18/2026 at 1:38 PM with WCN she stated she is frequently in-serviced on infection control to include EBP. She stated that residents with catheters, feeding tubes, wounds are the residents that would be placed on EBP. She stated that IP is the person responsible for placing the EBP signs on the door to indicate EBP. She stated that if a resident is on EBP they must wear gowns and gloves when providing close contact care and a mask if necessary. She stated she wears a mask when performing the wound care dressing changes. She stated if the proper PPE is not worn when providing care to residents on EBP they can potentially spread germs and cause infection to the residents.In an interview on 3/19/2026 at 3:23 PM with IP, she stated she has worked in the facility for 2 years and she is currently the Infection control nurse. She stated she and the staff are frequently in-serviced on infection control including EBP. She stated residents with wounds, catheters, colostomies, infections, dialysis, IVs, and PICC lines would all be placed on EBP. She stated if a resident is on EBP the staff must wear a gown, gloves and occasionally a mask when providing care to a resident. She stated that a CNA would know a resident had an order for EBP because there is a sign on the door and an EBP symbol next to the name plate. She stated she is responsible for putting the signs on the door but if she is not working when the order is input the nurse covering at the time should place the signs on the door. She stated they do huddles and in-services weekly to review the list of EBP residents with the staff including the CNAs. She stated she has made a cheat sheet for the CNAs. She stated that if the staff do not wear the proper PPE, they could get germs on their clothing and spread germs causing infections or the residents to get sick. She stated that she was sure that she had placed a sign on Resident #69's door, but they had a disgruntled staff that had been in the building the night before and they believe they may have pulled it down.In an interview on 3/19/2026 at 3:34PM with the DON she stated she has been working in the facility for a little over a year. She stated the staff are frequently in-serviced on infection control including enhanced barrier precautions. She stated that residents with indwelling devices, foley, IVs, Ports, and wounds are placed on EBP. She stated that a CNA would know a resident was on enhanced barrier precautions by PCC posted signs on doors and by the name plate and when they come on each shift the nurse will discuss in report to indicate who is on EBP. She stated if a resident is on EBP she expects staff to wear gowns and gloves when providing high touch care such as peri care, catheter care, or wound care. She stated that if staff do not wear the proper PPE, they can transmit germs and get the resident sick. She stated that they believe there was a sign on Resident #69's door the previous day, but they had a disgruntled employee in the building that they assume pulled them down and they have begun to re-inservice their employees where to find the needed information and not rely solely on the signs.In an interview on 3/19/2026 at 3:50 PM with ADM she stated she started in the facility on 02/01/2026. She stated that staff are frequently in-serviced on infection control to include (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP. She stated that a resident would be placed on EBP if they had c-diff (infection in the intestines), MRSA (drug resistant infection). She stated that a CNA would know a resident was on EBP by the sign on the door she stated it should be identified in the charting system, but she was unsure where as she was new to PCC. She stated that if a resident is on enhanced barrier precautions she expects staff to abide by the check-off sheet. She stated the IP and nurses are responsible for putting the sign on the door to indicate that a resident is on EBP. She stated that if staff do not wear the expected PPE, they can spread infection and germs and contamination from the staff to the residents.Record review of facility policy titled IPCP standard and Transmission-Based Precautions-Infection Control Original written date June 2023 with revision dates July 2022; October 2022 revealed that Enhanced barrier Protection (EBP): expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for direct transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (Residents with wounds and indwelling medical devices are at especially high risk of both acquisition of colonization with MDROs.) Examples of high contact resident care activities requiring gown and glove used for EBP include Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, Device care or use: central vascular line, indwelling urinary catheter, feeding tube, tracheostomy/ventilator, wound care.