STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676462	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Anthony's Care Center	7501 Bagby Ave. Waco, TX 76712

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interviews and record review the facility failed to provide care, consistent with standards of practice, to prevent pressure injuries for one resident (Resident #1) of six reviewed for pressure injuries. The facility failed to have a system in place to monitor Resident #1 for skin changes and prevent the development of right lateral foot and ankle blanchable redness from admission on 10/11/2024 through discharge on 10/13/2024. On 10/13/2024, when family attempted to examine Resident #1's foot, he made a sound and pulled his foot away from their touch. This failure could place residents at risk for the development of pressure injuries, wounds infection, and pain. Findings included: Review of Resident #1's face sheet dated 12/10/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Parkinson's Disease (movement disorder), arthritis (joint swelling and tenderness), weight loss, history of cerebral infarction (brain attack/stroke), and stenosis of the right carotid artery (narrowing of the blood vessel) Review of Resident #1's admission MDS dated [DATE] reflected resident #1 entered from Hospice/Home. Review of Resident #1's progress noted dated 10/11/2024 at 3:57 pm reflected resident was admitted from home on 10/11/2024 for a respite stay. Review of Resident #1's admission assessment dated [DATE] at 3:57 pm in section H Skin Integrity, reflected the resident's skin was a normal color, warm with normal turgor (elasticity), and no skin concerns noted. Review of Resident #1's Point of Care tasks dated 12/12/2024 at 2:06 pm reflected Resident #1 was to be turned and repositioned each shift and the tasks had been signed off as completed each shift while he was in the NF. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of hospice notes dated 10/14/2024 indicated Resident #1 was seen at home and he now has blanchable redness to right lateral foot and ankle. RN provided education on keeping feet floated and repositioning to prevent skin breakdown. During an interview with FM #1 on 12/10/2024 at 2:00 pm, they stated Resident #1 was admitted on [DATE] for a respite stay. They stated Resident #1 had been on hospice services at home and did not have any skin issues when he went to the Nursing Facility. They stated when they got Resident #1 home on the morning of 10/13/2024 his right foot had big red and purple marks down the side. They stated the skin was not broken but there were spots on his right foot where it looked like he had laid for a long time. During an interview with FM #2 on 12/10/2024 at 2:10 pm, they stated they picked up Resident #1 at the NF on 10/13/2024 and brought him home about 9:00 am. They stated he was smelly, very stiff, and grimacing when they moved him - which was not normal for him. They stated Resident #1 had socks on his feet when they got to the NF and they did not look at Resident #1's feet while still in the NF, they just changed him and got him ready to go home. They stated they got home about 9:15 am and started to clean up Resident #1 and change his clothes. They stated that's when they noticed the red marks along the side of his right foot that looked like blisters with purple centers. They stated they took pictures of Resident #1's foot and agreed to send them to this State Investigator. FM #2 stated they had had Resident #1 on hospice services at home and he had not had any skin breakdown when he was admitted to the NF. She stated when they tried to examine and clean the areas on his foot, he made a sound like a gasp or intake of breath and pulled his foot away. An interview with the hospice RN was attempted on 12/11/2024 at 2:31pm, but the RN was out on leave. During an interview with the DON on 12/12/2024 at 1:20 pm she stated she was not aware of any skin issues with Resident #1 after he was discharged . She stated her expectation was that staff would round on the residents every 2 hours and reposition per the task list in POC and sign the CNA tasks off in the EMR. The DON stated there was no procedure in place right now for a discharge skin assessment and no expectation that staff would have done an exit skin assessment on Resident #1 before he left the NF. The DON stated they do skin assessments upon admission and Resident #1 had a skin assessment completed . DON stated Resident #1 was only in the facility for 2 days and she would not have expected any skin issues and the Family didn't say anything after discharge about skin issues. In an interview with the AD on 12/12/2024 at 1:30 pm she stated she was not made aware of any skin issues with Resident #1 after he was discharged . She stated they did not have any procedures in place for respite residents to have skin assessments coming and going from the NF, but they would be putting new procedures in place to have both admitting and discharging skin assessments . Review of pictures from FM #2 dated 10/13/2024 and timestamped at 9:13 am reflected a bright red circle the size of a half dollar with a purple center in it on the outside of Resident #1's right heel, a bright red circle the size of a quarter with a purple center in it on the side of his right foot in the middle of his foot and a bright red area, larger than a half dollar, on the outside and underside of his right foot in pinky toe area, also with a purple center. The skin in the pictures did not appear broken, weeping, or having discharge. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of facility procedure 540 Positioning the Resident with an incomplete date of 2/14/2, reflected: Purpose, to change resident's position using good body mechanics, to relieve pressure and prevent skin breakdown, to relive pain, to promote proper body alignment. Procedure also reflected: Documentation may include date, time, body position, frequency of positioning .condition of skin.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interviews and record review the facility failed to provide pharmaceutical services to include the acquiring and administering of medications to meet the needs of each resident for 1 of 6 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1 received his prescribed medication for Parkinson's disease (disorder of the central nervous system that affects movement) from 10/11/2024 to 10/13/2024. Resident #1 missed 5 doses of this medication causing him discomfort and increase in symptoms. This failure placed residents at risk for pain, increases in symptoms, medical complications, and decreased quality of life. Findings included: Review of Resident #1's face sheet dated 12/10/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included: Parkinson's Disease (movement disorder), arthritis (joint swelling and tenderness), weight loss, history of cerebral infarction (brain attack/stroke), and stenosis of the right carotid artery (narrowing of the blood vessel) Review of Resident #1's admission MDS dated [DATE] reflected Resident #1 entered from Hospice/Home. Review of Resident #1's progress noted dated 10/11/2024 at 3:57 pm reflected the resident was admitted from home on 10/11/2024 for a respite stay. Review of Resident #1's hospice orders dated 10/11/2024 provided to the NF reflected an order for Carbidopa-Levodopa-Entacapone, 75-100-200 mg, one tablet, three times a day. Review of Resident #1's October 2024 MAR on 12/11/2024 reflected no listing or administration record for Carbidopa-Levodopa-Entacapone, 75-100-200 mg, one tablet, three times a day. During an interview with FM #2 on 12/10/2024 at 2:10 pm, they stated they picked up Resident #1 at the NF on 10/13/2024 and brought him home about 9:00 am. They stated he was smelly, very stiff, and grimacing when they moved him - which was not normal for him. She stated Resident #1 seemed different overall, she stated he did not speak in full sentences, only said one word. She stated when they changed him and moved him in the NF, he moaned and made faces and appeared in pain. She stated, It took a lot for [Resident #1] to say he was in pain and if he did or if he acted like it, he was probably in a lot of pain. She stated when they put him in the car, it was hard for him to move, and he made sounds of discomfort and the same thing happened when they got him home and took him out of the car and into the house. She stated when she got home, she noticed there was the same amount of his Parkinson's medication in the bottle as when she dropped it off and then she suspected the NF has not given him any of his Parkinson's medications and that's why he was so uncomfortable. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/11/2024 at 4:10 pm, the ADON stated she had been the one to complete the admission orders on Resident #1. She stated as she put the medication orders in, she put a checkmark by each medication. She stated there was no checkmark by the Carbidopa-Levodopa-Entacapone, 75-100-200 mg, because she had missed it and had not put the order in the EMR. She stated without the order, Resident #1 would not have gotten this medication. She stated the medication was for Resident #1's Parkinson's disease and without the medication he could have had increased tremors, lapses in mental status, discomfort, or other side effects from Parkinson's disease. During an interview on 12/11/2024 at 4:30 pm, the DON stated she was now aware that Resident #1 had not received his Parkinson's medication. She stated her expectation was that staff would input all admission orders completely so the residents received the required medications. She stated Resident #1 could have potentially had an increase in side effects from his Parkinson's disease by missing 5 doses. During an interview on 12/12/2024 at 9:09 am, the Hospice Medical Director stated he expected the orders to be carried out in the NF and we don't want that for any of our patients to miss any medication. He further stated Resident #1's Carbidopa-Levodopa-Entacapone, 75-100-200 mg, was a medication they would continue with their hospice patients until they could no longer swallow to help with symptoms. He stated Resident #1 missing 5 doses would not be life threatening but more of a symptom issue where there would be the potential for quite a bit of discomfort and pain .rigidity, motor dysfunction, stiffness - all having the potential to cause pain. Review of facility policy dated v1-2024, Medication Administration and General Guideline reflected medications are administered as prescribed, in accordance with State Regulation using good nursing principles and practices and only by persons legally authorized to do so. Further: #2 Medications are administered in accordance with written orders of the attending physician.