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	03/26/2026

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 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 one of one kitchen reviewed for sanitation. 1.The facility failed to ensure sanitation practices (ensuring staff utilized hair restraints, specifically beard guards while in the kitchen)2.The facility failed to label and date all food items in the kitchen.These failures could place residents at risk of foodborne illness. Findings included: In an observation on 03/24/2026 at 9:08 AM of the kitchen revealed DA F and DA G in dish room both washing breakfast dishes. DA F observed unloading the dish machine and putting away clean dishes. DA F observed without beard guard on further observation revealed DA F had facial hair of mustache. DA G observed loading dirty dishes into dish machine further observation revealed DA G had a face mask on down under bottom lip covering chin no beard guard observed on DA G. DA G observed with facial hair of mustache and patchy facial hair on both cheeks. In an observation on 03/24/2026 at 9:13 AM of kitchen refrigerator #1 revealed the following:-container of vanilla pudding dated 3/17/26 unsure if this is preparation date or discard date.-gallon bag of turkey breast dated 3/23 unsure if this is preparation date or discard date.-quart size bag of pimentos dated 3/22 unsure if this is preparation date or discard date.-container of fruit cocktail dated 3/22 unsure if this is preparation date or discard date.-container of turkey dated 3/23/26 unsure if this is preparation date or discard date.-container of sweet potatoes dated 3/23/26 unsure if this is preparation date or discard date.-4 individual bowls of what appeared to be chocolate pudding undated and unlabeled-3 insulated mugs of unidentified liquids undated and unlabeled-container of green bean casserole dated 3/23/23 unsure if this is preparation date or discard date.-2 pitchers of what appeared to be cranberry juice unlabeled and undated-1 pitcher of what appeared to be apple juice unlabeled and undated-1 pitcher of what appeared to be orange juice unlabeled and undated-2 pitchers of what appeared to be milk unlabeled and undated-1 pitcher of what appeared to be tea unlabeled and undated-gallon bag of individual containers of ranch dressing dated 3/15 unsure if this is preparation date or discard date.-gallon bag of individual containers of ketchup dated 3/15 unsure if this is preparation date or discard date.-gallon bag of individual containers of sour cream dated 3/18 unsure if this is preparation date or discard date.-container of bananas dated 3/23 unsure if this is preparation date or discard date.In an observation on 03/24/2026 at 9:17 AM of kitchen freezer revealed the following:-bag of what appeared to be breaded steak patties unlabeled and undated.-bag of what appeared to be churros dated 3/17 unsure if this is open date or discard date.-bag of what appeared to be diced chicken dated 3/18 unsure if this is open date or discard date.-bag of beef patties dated 3/24 unsure if this is open date or discard date.In an observation on 03/24/2026 at 9:20 AM of kitchen refrigerator # 2 revealed the following:-quart size bag of bell peppers dated 3/23 unsure if this is preparation date or discard date.-quart size bag of purple onion dated 3/4 unsure if this is preparation date or discard date.-container of pureed tomato dated 3/23 unsure if this is preparation date or discard date.In an observation on 03/24/2026 at 9:29 AM of kitchen dry storage pantry revealed the following:-gallon bag with open container of cream of wheat with an open date of 3/18 no received date or discard date-gallon bag of open bag of chip with a received date of 3/17 and an open (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	date of 3/22 no discard date.-gallon bag of open bag of gelatin mix dated 2/2/26 unsure if this is received date, open date or discard date.-quart bag of open country gravy mix with received date of 2/27 and open date of 3/7 no discard date.-quart bag of open brown gravy mix with received date 3/3 and open date 3/12 no discard date.-gallon bag of open bag of brown sugar dated 3/14 unsure if this is received date, open date, or discard date.-gallon bag of open dry spaghetti dated 1/25 unsure if this was the received date, open date, or discard date.In an observation on 03/24/2026 from 12:00 PM-12:45 PM of dining room revealed DA F observed going in and out of kitchen delivering meal trays and delivering speed racks with hall meal trays to nursing staff in dining room. DA F observed without beard guard during the entire meal service.In an observation on 03/25/2026 at 9:48 AM of kitchen revealed DA F and DA G in dish room both washing breakfast dishes. DA F observed unloading the dish machine and putting away clean dishes without beard guard revealing facial hair of mustache. DA G observed loading dirty dishes into dish machine with face mask on down under bottom lip covering chin no beard guard observed on DA G. DA G observed with facial hair of mustache and patchy facial hair on both cheeks. In an observation on 03/25/2026 at 10:15 AM DA G was cutting cornbread with face mask on down under bottom lip covering chin. There was no beard guard observed exposing facial hair of mustache and patchy facial hair on both cheeks. DA F was bagging cut cornbread without beard guard exposing facial hair of mustache.In an interview on 03/26/2026 at 1:43 PM the DS stated items are dated upon receipt with received date. DS stated items are dated with the day the item was opened, name of item, and use by date. DS stated all kitchen staff and ultimately the DS and DM are responsible for ensuring food items are labeled and dated. DS stated staff received hands-on training on the job upon hire with food labels and how to properly fill out labels. FIFO is followed. DS stated In-services covering labeling and dating are also conducted. DS stated residents could potentially be negatively impact if food items are not labeled and dated appropriately because of foodborne illness from outdated or expired food items. DS stated all staff with facial hair or a beard or moustache are required to wear beard guards. DS stated it was ultimately the managers who are responsible for ensuring hair restraint protocols are maintained in the kitchen. DS stated upon hire hair restraints were covered during kitchen training and hair restraints are kept near the back door and must be always worn while in the kitchen. DS stated it could potentially negatively impact a resident if hair restraint protocols are not maintained in the kitchen because nobody wants hair in their food.In an interview on 03/26/2026 at 2:24 PM the DM stated the staff label and date upon receipt, upon open or preparation and with a discard date and name of item. DM stated well with us being short staffed the DM and DS and all kitchen staff are responsible for ensuring food items are labeled and dated appropriately. The DM stated she verbally repeated to staff about labeling and dating protocol. The DM stated staff were trained upon hire and during in-services. The DM stated it could potentially negatively impact a resident if food items were not labeled and dated appropriately because it could make a resident sick. The DM stated if staff were bald, hair restraints were not required. DM stated hair restraints are required for all people who enter the kitchen including staff, contractors, and vendors. The DM stated for any staff with facial hair beard guards are to be worn. The DM stated beard guards are kept in dry storage pantry. The DM stated it was the responsibility of the DM and DS to ensure hair restraint protocols are being maintained. The DM stated she discussed hair restraints upon hire and during in-services. The DM stated it could potentially negatively impact a resident if staff hair restraints protocols are not maintained in the kitchen because hair could get into the food. In an interview on 03/26/2026 at 2:30 PM DA G revealed everything should be labeled and dated with the receipt date, prep date, and discard date. DA G stated all staff are responsible for food labeling and dating. DA G stated staff are trained upon hire and during in-services regarding food labeling and dating. DA G stated it could potentially negatively impact a resident if food items are not properly labeled and dated. DA G stated hair nets and beard guards are required for any loose hair including mustaches. DA G stated he just did not realize the face mask he was wearing did not cover all his facial hair. DA G stated the supervisors and the staff themselves are responsible for ensuring (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hair restraints are worn while in the kitchen. DA G stated staff are trained in hair restraints upon hire and during in-services. DA G stated it could potentially negatively impact on a resident if hair restraints are not worn because hair could get into the food. In an interview on 03/26/2026 at 2:46 PM DA F stated food items are labeled and dated. DA F stated all staff are responsible for labeling and dating. DA F stated he was unsure how staff are trained in food labeling and dating. DA F stated it could potentially negatively impact on a resident if food was not labeled and dated. DA F stated that hair restraints need to be worn even for mustaches. DA F stated the supervisor was responsible for ensuring hair restraints are worn while in the kitchen. DA F stated he was unsure about hair restraint training. DA F stated it could potentially negatively impact a resident if hair restraints are not worn. DA F could not provide an answer as to why he was not wearing a beard guard. In an interview on 03/26/2026 at 3:30 PM the DON stated the policy was to label and date items upon receipt, upon open or prep and to be discarded in 3 days. DON stated DM, DS, cooks, and DAs are responsible for labeling and dating food items. DON stated for food labeling and dating training the DM, DS, and RD conduct in-services. DON stated it could potentially negatively impact a resident if food items are not labeled and dated because of food spoilage. DON stated all staff who have facial hair, including mustaches, should wear beard guards. DON stated staff are trained in hair restraints by in-services conducted. DON stated yes it could potentially negatively impact a resident if hair restraints are not worn.In an interview on 03/26/2026 at 3:40 PM with the ADM, she stated the policy was to label and date items upon receipt, upon open or prep and to be discarded in 3 days. ADM stated DM, DS, cooks, and DAs so all kitchen staff are responsible for labeling and dating all food items in the kitchen. ADM stated for food labeling and dating training the DM, DS, and RD conduct in-services and staff are trained upon hire. ADM stated it could potentially negatively impact a resident if food items are not labeled and dated because of food spoilage and bacteria growth. ADM stated all staff who have hair are required to wear a hair restraint and all staff who have facial hair, including mustaches, should wear beard guards. ADM stated staff are trained in hair restraints by in-services conducted and upon hire about hair restraint expectations. ADM stated yes it could potentially negatively impact a resident if hair restraints are not worn by hair getting into the food.In an interview on 03/26/2036 at 3:53 PM the RD stated food items should have a receipt date. The RD stated food items were dated upon opening or preparation and then discarded after 3 days for perishable items. The RD stated if the facility had a system in place for labeling and dating there should not need to be a discarded date. Record review of kitchen in-services reflected the following:* in-service dated 11/17/25 with title food safety, hygiene, handwashing, and temperatures conducted by RD with 9 staff signatures. *in-service dated 12/25/25 titled food allergy, food safety and sanitation conducted RD with 8 staff signatures. *In-service dated 1/17/25 titled kitchen procedures and policies conducted by DS with 7 staff signatures. *In-service dated 2/25/26 titled allergies, coffee temperatures, textures, and infection control conducted by RD with 9 staff signatures.Record review of facility employee hygiene policy undated reflected under heading procedure:6. Employees must keep hair from contacting exposed food, clean equipment, utensils, and linens.Record review of facility hair net policy undated reflected under heading procedure:-It is mandatory that all dietary staff wear hairnets while on duty in any food preparation area this facility.-Any person with a beard must wear a beard net. -Bald persons are excluded from wearing hair nets and clean-shaven persons are excluded from wearing beard nets.-It is at the discretion of the dietary manager to determine the necessity of hair and beard nets.Record review of facility dry storage and supplies policy undated reflected under heading policy:All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry, and protected from vermin, and insects.Under heading procedure:4. Open packages of food are stored in closed containers with tight covers and dated as to when opened. Record review of facility storage of food in refrigeration policy undated reflected under heading procedure:4. All containers must be labeled with contents, and the date food item was placed in storage. 5. Previously cooked foods can be held in refrigeration of 41 degrees F or lower for 3 days-being discarded by day 4.

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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 observation, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 3 (Resident #3, Resident #30, and Resident #94) of 16 residents reviewed for resident rights. 1. The facility failed to ensure Resident #3, and Resident #30 were fully informed and aware of their rooms being searched and why items were taken from their rooms. 2. The facility failed to assess Resident #3 and Resident #30 in their abilities to safely use razors and/or scissors, according to the facility policy, before removing them from their possessions.3. The facility failed to honor Resident #94's rights when he was being fed in the dining room by CNA C, who was standing while feeding the resident, violating his right to dignity.These failures could place residents at risk for psychosocial harm, isolation, poor self-esteem and/or feeling like they were a burden or being rushed to finish their meals, which could result in decreased food intake. Findings included:Resident #3Review of Resident #3's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #3 had the following diagnoses: anxiety (feelings of worry, nervousness, or unease), depression (mood disorder characterized by persistent feelings of sadness and loss of interest), obsessive-compulsive personality disorder (mental health disorder characterized by a pervasive preoccupation with orderliness, perfectionism, and control), mild intellectual disabilities, developmental disorder of scholastic skills (conditions that impair one's ability to acquire fundamental academic skills, such as reading, writing, and arithmetic). Resident #3's functional skills indicated he had clear speech, the ability to make himself understood, and to understand others, he had adequate vision and required substantial assistance with personal hygiene. Resident #3 had a BIMS score of 15, indicating intact cognition. Review of Resident #3's comprehensive care plan dated 07/23/2023 reflected that Resident #3 had adequate vision and was able to see fine detail including regular print. Resident #3 was indicated as being PASRR positive for ID and was confirmed by the evaluation conducted by the LIDDA. Review of Resident #3's assessment history in the EMR reflected there was no Safety Assessment conducted dating back to 06/2025-03/2026 to evaluate Resident #3's ability to safely shave himself.In an interview and observation on 03/24/2026 at 9:41 AM with Resident #3, he stated that he wanted to know why the facility took his [name brand] disposable razors away from him. He stated that the staff did not tell him why they were taking his razors, but he also was not sure who took the razors. There was a 3-head electric razor observed, through the open bathroom door, sitting on his bathroom counter. He stated that the electric razor in his bathroom was not his preferred razor of choice, and that it left stubble on his face when he used it. He exclaimed that he wanted to be told why his disposable razors were not in his room anymore and that he wanted them back. In an interview on 03/26/2026 at 11:47 AM with CNA C, she stated that she had been working for the facility almost 2 years, and that she sometimes worked with Resident #3. She stated she had recently shaved Resident #3 with a disposable razor, and that Resident #3 did not keep any kind of razors in his room. She stated that Resident #3 had an RP that would bring him things. She stated she had never been aware of disposable razors in his room, and that she had not confiscated any. She stated she was aware that he wanted disposable razors, but the staff tell him that for his safety and others, it was best that the staff kept the razors and that they provided the care to him. She stated she did not have any residents on her hall who wandered into others' rooms. She stated that she and a coworker performed room searches a couple weeks ago at the direction of the SC, but that everyone (residents) were aware of what was going on, and that the staff informed the residents of what items and why the items were being removed from the resident's possession. She stated that she was not aware of the nurse conducting a safety assessment and allowing the residents to keep any of those (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prohibited items. She stated a negative impact of having an electric razor in his room could be cuts or electrocution if gotten wet.In an observation on 03/26/2026 at 11:45 AM revealed the MDSC and other staff walking into Resident #3's room, then exiting a few minutes later. The MDSC informed the state surveyor that the electric razor had been removed from Resident #3's room. Resident #30Review of Resident #30's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #30 had a diagnosis of anxiety. Resident #30's functional abilities revealed she had no upper extremity impairments, required moderate assistance with personal hygiene, and was independent with dressing her upper body. Resident #30 had a BIMS score of 15, indicating intact cognition. Review of Resident #30's comprehensive care plan dated 08/28/2024 reflected that Resident #30 had adequate vision and was able to see fine detail including regular print. Her care plan indicated her ability for decision making was strong.Review of Resident #30's assessments revealed no Safety assessment conducted dating back to 11/2025-03/2026 to evaluate Resident #30's ability to safely use scissors. In an interview on 03/24/2026 at 1:54 PM with Resident #30 she stated that she had scissors and 2 fingernail clippers in the bottom drawer of a side table located adjacent from her bed and under the television, but someone had taken them. She stated she was not sure who took them. She stated that the facility did go over prohibited items with her, and that scissors and fingernail clippers were mentioned. She stated that she was sleeping in bed one night, and she did not know how many people, but they came in and took the scissors and fingernail clippers from her side table. She stated that she went to bed fairly early each day (7:30pm) and she did not know what time the people went into her room, but they did not tell her what they were taking or why. In a follow-up interview on 03/25/2026 at 7:22 PM with Resident #30 she stated that the facility staff often reminded her that this is your home and that she should feel safe here, but she stated that she did not feel safe because too many of her personal belongings were used for other people, or taken without her permission. She stated that her RP had brought her a pair of child scissors that did not have a pointed tip, and that she used them to cut strings off her clothing, or to open up her snacks. She stated that one day she went to grab them out of her plastic bag that she kept in a drawer adjacent from her bed, and they were not there. She stated that someone had to have taken them when she was sleeping because she did not recall anyone telling her they were taking them, or why they would have been taken from her.In an interview on 03/26/2026 at 11:15 AM with CNA A who had been working for the facility for a little over a year, and CNA B who had been working for the facility for almost 2 years revealed that they both typically worked Resident #30's hall. They both stated that resident prohibited items included scissors, nail clippers, anything sharp, alcohol-based stuff, extension cords, microwaves, hair dryers, and aerosol cans. They stated that residents were not supposed to keep razors in their rooms, and that residents were supposed to ask staff to assist them with shaving needs. Neither CNA was aware of there being a facility Safety Assessment to determine a resident's ability to keep those prohibited items. CNA A stated that she and another CNA were instructed by the SC to go into resident rooms a couple weeks ago, during the day, to let residents know they were not supposed to have things that were harmful to them or other residents. She stated that she did confiscate scissors from Resident #30, and that she informed the resident she was taking them. She stated the confiscated items were put in bags and given to the office personnel. In an interview on 03/26/2026 at 12:21 PM with the ADON, she stated that she knew CNA's conducted room searches but she did not know what was taken out of each room. She stated that during angel rounds the staff would notify the families to pick up the confiscated items. She stated she had not performed a safety assessment of Resident #30. She stated that based off what she knew about Resident #30, she did not think it was safe for her to have scissors, and she could not say that the facility did not have other residents who could potentially go in the room, and it could be a safety risks to other residents if the scissors were obtained. She stated that a negative impact would be that the residents could be upset about not being able to do something for themselves anymore. In an interview on 03/26/2026 at 11:57 AM with the SC, she stated that she was in charge (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of implementing room searches, and that she had 2 staff go in each room, they would introduce themselves, tell residents they were there to do routine searches, and looked for and confiscated prohibited items. She stated that she trusted that the CNA's asked residents for permission to search their rooms, and that they let the residents know what they were confiscating, what the CNA's were doing with the items, and why they were removing them. She stated the items would then be brought to the SC, and that during angel rounds, the staff assigned to that particular would contact the RP to pick up the items. She stated that they did not make progress notes in the EMR when items were confiscated. She stated she thought residents were care planned for having prohibited items in their rooms. She stated that Resident #30 was known to go to bed early, but the CNA's would have told her what they were doing and why, and Resident #30 may not have known what time of night it was. She stated that the ADM was in Resident #3's room when they conducted his search. She stated they confiscated disposable razors out of his room, along with a pack of 30 razor heads, an electric razor, and aerosol cologne. She stated that if a safety assessment was conducted then residents could keep some of those items, but she was not aware if any assessments were conducted. She believed the ADON or ADM conducted those assessments. She stated that she looked at the prohibited items policy when she first started, but she did not think to have someone assess the residents after they retrieved the prohibited items from their rooms. She stated a negative impact of taking items that residents had the ability to safely use, could be that the residents would be upset, made them feel less like an adult, and treated like a kid. In an interview on 03/26/2026 at 12:31 PM with the ADM, she stated that Resident #30 had sharp scissors in her room, and that they had them bagged for the RP to pick up. She stated that CNA's went into resident rooms when the residents were awake, and that Resident #30 had previously claimed that people came into her room, and that people went in her closet. She stated that she thought Resident #30 would not be safe to have scissors in her possession because of her impaired vision and that she did not know what Resident #30 would use them for, but that a safety assessment had not been completed. She stated that she would not think Resident #3 was safe to shave himself because some days he was fine but somedays he had jerking motions with his hands. She stated that the RP for Resident #3 must have brought the electric razor back to him without staff knowledge. A negative impact would be that the residents could be upset about no longer having those items. Review of the facility's policy titled ?Items Prohibited in Resident Rooms', undated, reflected, To protect resident safety, prevent accidents, reduce fire hazards, and maintain regulatory compliance, certain items are strictly prohibited from being stored or kept in resident rooms. Staff must remove prohibited items immediately and follow proper storage, documentation, and reporting procedures. The following items must NOT be kept in a resident's room under any circumstances:1. Hazardous or Dangerous Items Razors (disposable or electric unless care-planned and secured) Scissors (unless approved through safety assessment)2. Resident NotificationsExplain respectfully: Why the item is not allowed Where it will be stored How they can request supervised access (if applicable)3. Safety AssessmentIf the resident insists on keeping: Razors Scissors Certain personal itemsA safety assessment must be completed by nursing and approved by the Administrator/DON.Resident #94Review of Resident #94 admission face sheet dated 3/25/26 reflected a [AGE] year-old male admitted on [DATE] with a diagnosis of senile degeneration of the brain (progressive age-related neurological decline), schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms with major mood disorder symptoms such as mania or depression), Alzheimer's disease (a progressive irreversible neurodegenerative disorder that destroys brain cells causing cognitive decline, memory loss, and behavioral changes), unspecified dementia (a diagnosis used when a patient shows clear signs of cognitive decline but the specific cause remains unclear), bipolar disorder (a chronic mental health condition characterized by intense extreme shifts in mood, energy, and activity levels), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life),.Review of Resident #94 quarterly MDS dated [DATE] reflected under section C-Cognitive (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patterns a severely impaired. Further review of section GG Functional Abilities dependent on staff for all ADLs including eating.Review of Resident #94 care plan dated 9/26/25 reflected Resident #94 at risk for weight changes and malnutrition r/t severe cognition impairment and dependence on staff assistance with eating with interventions of provide set-up, supervision, verbal cue, and physical assistance as needed to complete meals.Review of Resident #94 clinical physician orders undated reflect a diet order of regular diet, pureed texture, nectar consistency dated 9/10/25.In an observation on 03/25/2026 at 12:08 PM CNA C was standing next to Resident #94 while assisting to feed him his lunch meal. Further observation revealed CNA C only to be feeding Resident # 94 while in the dining room. In an interview on 03/26/2026 at 12:15 PM, with ADON E, she stated the CNA who was assisting to feed Resident # 94 was an agency CNA and she was unsure of her name, but she could provide the surveyor with that information. ADON E stated that all agency staff go through a competent skills check-off before being released to work on the floor and that training was provided by the SC.In an interview on 03/26/2026 at 1:15 PM, with CNA C, she stated she worked for an agency but had worked at the facility several times prior to her shift on 33/25/2026. CNA C stated she had received no training from the facility prior to working on the floor with residents. CNA C stated she was standing while feeding Resident # 94 because she was feeding 2 residents at the same time. CNA C stated she knew she was supposed to be sitting next to the resident while feeding him. CNA C stated she was aware that it could be a violation of resident rights for standing while feeding a resident as it could make them feel rushed. In an interview on 03/26/2026 at 3:12 PM, with the SC, she stated that on the agency's website there was a competency test that the agency required their staff to complete prior to being able to sign up to work shifts at any nursing facility. The SC stated the competency test covered resident rights. The SC further stated that at the facility level, for any agency staff prior to working the floor with residents the staff completed a competency checklist and it was reviewed by the SC to ensure understanding and completion. The SC stated the competency checklist covered resident rights. The SC stated the staff were asked to explain the steps of each competency item and the SC watched the staff perform hand hygiene, peri-care, and mechanical lift transfers. The SC stated it was her responsibility to ensure agency staff were adequately trained on facility policy and procedures before assuming resident care. The SC stated it would be a resident rights concern for a staff member to be standing while feeding a resident because it could make the resident feel rushed, degraded, and decrease the amount they ate. The SC stated if agency staff were found in violation of any of the facility policies and procedures they were no longer allowed to work at the facility.In an interview on 03/26/2026 at 3:30 PM with the DON, she stated that the SC had a protocol of training checkoffs that was completed by agency staff prior to them assuming any resident care. The DON stated it was the responsibility of the SC to ensure all agency staff were adequately trained prior to assuming resident care. The DON stated it would be a resident rights concern for a staff member to be standing while assisting to feed a resident because it would be a dignity issue. The DON stated if agency staff were found in violation of facility policy and procedure, they were listed on a do not rehire list and were no longer allowed to be employed by the facility. In an interview on 03/26/2026 at 3:40 PM with the ADM, she stated it was the responsibility of the SC to ensure all agency staff had completed the competency training prior to assuming patient care. The ADM stated it would be a resident rights concern for a staff member to stand while feeding residents because of it being a dignity issue and potentially making the resident feel degraded, rushed, and like they did not matter. The ADM stated if agency staff violated the facility policies and procedures they were put on a list and no longer allowed to work for the facility.Record review of CNA C facility competency check-off reflected training received covering meal support, hand hygiene, hand washing, sepsis and bacterial infections, foam in foam out, dated 3/16/26.Review of facility Do Not Rehire list, undated, reflected CNA C was listed due to on phone while feeding infection control.Review of CNA In-service: Etiquette & Behavior, undated, reflected under heading purpose: To ensure all CNAs maintain professionalism, provide safe care, represent the facility positively when (continued on next page)

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	676462	A. Building B. Wing	03/26/2026

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	state surveyors are present.2. Focus on Resident Care-always prioritize resident safety, dignity, and comfort-follow care plans exactly as written6. Dining room etiquette and mealtime behavior.-Engage respectfully (make eye contact, speak kindly, maintain dignity).Review of the facility's policy titled ?Food Service to Residents', undated, reflected under heading purpose: Food will be prepared and served in a manner that meets the individual needs of the resident.Under heading procedure:2. Residents who require assistance in eating:.d. Residents who are unable to feed themselves will be fed with attention to safety, comfort, and dignity.Review of the facility's policy titled ?Protecting and Ensuring Resident Rights', undated, reflected under heading procedure 3. All staff will be advocates for resident rights4. All staff will receive training on resident rights prior to assignment5. The list of residents' rights will be available for residents to review at any time.Review of the facility's policy titled ?Resident Rights', undated, reflected under heading purpose: -To ensure that resident rights are respected and protected-To inform residents of their rights and provide an environment in which they can be exercisedUnder heading procedure:Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. Following is a list of residents' rights recognized by management and employees as well as local, state, and federal laws and regulations.The resident has the right-To a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.-To be treated with respect and dignityOverall customer service standardEvery interaction should reflect kindness, patience, professionalism, and respect for resident rights. Staff should treat each resident as they would want their own family treated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interviews, and record review 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 1 of 8 residents (Resident #3) reviewed for care plans.The facility failed to care plan Resident #3's use and possession of an electric razor, that was stored in his room.This failure could place residents at risk of not receiving necessary care and services. Findings included:Review of Resident #3's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #3 had the following diagnoses: cancer, heart failure, high blood pressure, renal failure, arthritis (conditions that cause joint pain, inflammation, and damage affecting one or more joints), anxiety (feelings of worry, nervousness, or unease), depression (mood disorder characterized by persistent feelings of sadness and loss of interest), obsessive-compulsive personality disorder (mental health disorder characterized by a pervasive preoccupation with orderliness, perfectionism, and control), mild intellectual disabilities, developmental disorder of scholastic skills (conditions that impair one's ability to acquire fundamental academic skills, such as reading, writing, and arithmetic). Resident #3's functional skills indicated he had clear speech, the ability to make himself understood, and to understand others, he had adequate vision and required substantial assistance with personal hygiene. Resident #3 had a BIMS score of 15, indicating intact cognition. Review of Resident #3's comprehensive care plan dated 07/23/2023 reflected that Resident #3 had adequate vision and was able to see fine details including regular print. Resident #3 was indicated as being PASRR positive for ID and was confirmed by the evaluation conducted by the LIDDA. Review of Resident #3's assessment history in the EMR reflected there was no Safety Assessment conducted dating back to 06/2025-03/2026 to evaluate Resident #3's ability to safely shave himself.In an observation on 03/24/2026 at 9:42 AM of Resident #3's bathroom revealed the door open, and a 3 head electric razor sitting on the countertop near the sink. In an interview and observation on 03/25/2026 at 7:38 PM with Resident #3, he stated that he had an electric razor in his bathroom, but it did not work as well as the disposable razors he had. He stated that the electric razor left stubble on his face. He stated he just wanted to know where his disposable razors were and why they were taken from him. He stated he could shave himself and was upset his property was taken away without anyone telling him why. Resident #3 appeared clean shaven, with no signs of cuts on his face.In an interview on 03/26/2026 at 10:00 AM with the MDSC, she stated she had been working at the facility for the last 6 weeks. She stated she would not consider Resident #3 safe to shave with a disposable razor, due to him being PASARR+. She stated that an electric razor may be more appropriate, but that it should be added to his care plan. In an interview on 03/26/2026 at 11:47 AM with CNA C, she stated that she has been working for the facility almost 2 years, and that she sometimes worked with Resident #3. She stated she had recently shaved Resident #3 with a disposable razor, and that Resident #3 did not keep any kind of razors in his room. She stated that Resident #3 had an RP that would bring him things. She stated she has never been aware of disposable razors in his room, and that she had not confiscated any. She stated she was aware that he wanted disposable razors, but the staff tell him that for his safety and others, it was best that the staff kept the razors and that they provided the care to him. She stated a negative impact of having an electric razor in his room could be cuts or electrocution if gotten wet.In an interview on 03/26/2026 at 12:31 PM with the ADM, she stated that she would not think Resident #3 was safe to shave himself because some days he was fine but somedays he had jerking motions with his hands. She stated that the RP for Resident #3 must have brought the electric razor back to him without staff knowledge. She stated that he could be assessed for safety and care planned for the possession of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the electric razor if he was determined to be safe to have it. A negative impact would be that the residents could be upset about no longer having those items. Review of the facility's policy titled ?Items Prohibited in Resident Rooms', undated, reflected, To protect resident safety, prevent accidents, reduce fire hazards, and maintain regulatory compliance, certain items are strictly prohibited from being stored or kept in resident rooms. Staff must remove prohibited items immediately and follow proper storage, documentation, and reporting procedures. The following items must NOT be kept in a resident's room under any circumstances:1. Hazardous or Dangerous Items Razors (disposable or electric unless care-planned and secured)Review of the facility's policy titled ?Comprehensive Care Plans', undated, reflected, 1. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment2. The comprehensive care plan will describe the following:a. The services that are to be furnished to attain the residents' highest practicable physical, mental, and psychosocial well-beingb. Any services that would otherwise be required but are not provided due to a resident exercising their right to refuse treatment and services.

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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 1of 8 residents (Resident #94) reviewed for infection control. The facility failed to ensure CNA C did not blow on on each bite of food to cool it off before feeding it to Resident #94.This deficient practice could place residents at risk by exposing them viral infections, secondary infections, communicable diseases. Findings included: Record review of Resident #94 admission face sheet dated 3/25/26 reflected a [AGE] year-old male admitted on [DATE] with a diagnosis of senile degeneration of the brain (progressive age-related neurological decline), schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms with major mood disorder symptoms such as mania or depression), Alzheimer's disease (a progressive irreversible neurodegenerative disorder that destroys brain cells causing cognitive decline, memory loss, and behavioral changes), unspecified dementia (a diagnosis used when a patient shows clear signs of cognitive decline but the specific cause remains unclear), bipolar disorder (a chronic mental health condition characterized by intense extreme shifts in mood, energy, and activity levels), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), hypertension (high blood pressure), benign prostatic hyperplasia (enlarged prostate gland).Record review of Resident #94 quarterly MDS dated [DATE] reflected the resident was severely cognitively impaired. Further review of section GG Functional Abilities: indicated the resident was dependent on staff for all ADLs including eating.Record review of Resident #94 care plan dated 9/26/25 reflected Resident #94 at risk for weight changes and malnutrition r/t severe cognition impairment and dependence on staff assistance with eating with interventions of provide set-up, supervision, verbal cue, and physical assistance as needed to complete meals.Record review of Resident #94 clinical physician orders undated reflect a diet order of regular diet, pureed texture, nectar consistency dated 9/10/25.In an observation on 03/25/2026 at 12:08 PM CNA C blew on each bite of food before presenting it to Resident #94 to eat. In an interview on 03/26/2026 at 1:15 PM with CNA C, she stated she worked for an agency but had worked at the facility several times prior to her shift on 03/25/2026. CNA C stated she had received no training from the facility prior to working on the floor with residents. CNA C stated she had never worked at a facility where the food was so hot. CNA C stated she knew she messed up looking back on the events. CNA C stated she knew she should not have been blowing on Resident # 94's food before feeding it to him. CNA C stated it was just her ?mom instinct' kicking in because the food was too hot and she did not think of another way to cool the food down before giving it to the resident. CNA C stated it could potentially be an infection control concern for blowing on Resident # 94's food if she was sick. In an interview on 03/26/2026 at 12:15 PM with ADON E, she stated the CNA who was assisting to feed Resident # 94 was an agency CNA. ADON E further stated that all agency staff went through a competent skills check-off before being released to work on the floor and that training was provided by the SC.In an interview on 03/26/2026 at 3:12 PM with the SC, she stated on the agency website there was a competency test that the agency required their staff to complete prior to being able to sign up to work shifts at any nursing facilities. The SC stated this competency test covered resident rights and infection control. The SC further stated that at the facility level, for any agency staff prior to working the floor with residents, the staff completed a competency checklist and it was reviewed by the SC to ensure understanding and completion. The SC stated this competency checklist covered infection control. The SC stated the staff were asked to explain the steps of each competency item and the SC watched the staff perform hand hygiene, peri-care, and mechanical lift transfers. The SC stated it was her responsibility to ensure agency staff were adequately trained on facility policy and procedures before assuming (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident care. The SC stated it would be an infection control concern for a staff member to be blowing on food before providing it to a resident because of possible infection being spread through them blowing on the food item and making the resident sick. SC stated if agency staff are found in violation of any of the facility policies and procedures they are no longer allowed to work at the facility.In an interview on 03/26/2026 at 3:30 PM with the DON, she stated that the SC had a protocol of training checkoffs that was completed by agency staff prior to them assuming any resident care. The DON stated it was the responsibility of the SC to ensure all agency staff were adequately trained prior to assuming resident care. The DON stated it would be an infection control concern for a staff member to be blowing on a resident's food prior to providing the food to the resident because the spread of germs can cause infection. The DON stated if agency staff were found in violation of facility policy and procedure, they were listed on a ?do not rehire' list and were no longer allowed to be employed by the facility. In an interview on 03/26/2026 at 3:40 PM with the ADM, she stated it was the responsibility of the SC to ensure all agency staff had completed the competency training prior to assuming patient care. The ADM stated it would be an infection control concern for a staff member to blow on resident food because the spread of germs could cause infection in an already compromised clientele. The ADM stated if agency staff violated the facility policies and procedures they were put on a list and no longer allowed to work for the facility.Record review of CNA C facility competency check-off reflected training received covering meal support, hand hygiene, hand washing, sepsis and bacterial infections, foam in foam out, dated 3/16/26.Record review of CNA In-service: Etiquette & Behavior undated reflected under heading purpose:To ensure all CNAs maintain professionalism, provide safe care, represent the facility positively when state surveyors are present.6. Dining room etiquette and mealtime behavior.-check food temperature appropriately before serving-NEVER blow on resident's food to cool it off (infection control violation)-Use approved methods to cool food (stirring, allowing time to cool, or requesting assistance)