STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455489	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeffrey Place Healthcare Center	820 Jeffrey Dr Waco, TX 76710

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review, the facility failed to notify the resident representative regarding a change in the resident's condition, for one (Resident #2) of six residents reviewed for changes in condition. , in that: The facility failed to inform Resident #2's Representative (RP) when Resident #2 was found in Resident #1's room on 5/25/2024 while Resident #1 was masturbating behind his curtain . This failure could place residents at risk of not having their Responsible Party notified of changes resulting in a delay in decision making for medical interventions. The findings included: Review of Resident #1's face sheet dated 6/26/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Mood Disorder, Diabetes mellitus (blood sugar regulation disorder), Alcohol abuse, Pulmonary hypertension (a type of hypertension that affects arteries in the lungs and heart) due to lung diseases, Atrial fibrillation (heart rhythm disorder involving the atria of the heart) and Ventricular fibrillation (heart rhythm disorder involving the ventricles of the heart). Review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 10 suggesting moderate cognitive impairment. Review of section E - Behavior reflected resident had not had any behaviors related to hallucinations delusions, physical behaviors, verbal behaviors, wandering or rejection of care behaviors. Review of Resident #1's progress note dated 5/25/2024 by LVN A reflected Resident in room with penis out playing with self in front of another resident when staff came in to remove [sic Resident #2] he started yelling and cursing at staff to get out of room. Message left for family and [Nurse Practitioner] made aware. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's face sheet dated 6/26/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (progressive disease that destroys memory and other important mental functions), unspecified dementia (progressive memory loss disorder), Generalized anxiety disorder, femur head fracture (broken hip), muscle weakness, lack of coordination, Dysphagia (difficulty swallowing), neuropathy (nerve pain), and Hypertension (high blood pressure). Review of Resident #2's quarterly MDS assessment dated [DATE] reflected Resident #2 could not complete the BIMS scoring assessment in Section C. The staff assessment section (C700) was completed and indicated resident had a long-term and short-term memory problem and her decision-making skills were severely impaired. Review of Section E - Behaviors, reflected Resident #2 had wandering behaviors behavior of this type occurred daily Review of Resident #2's progress notes printed 6/26/2024 reflected no entry on 5/25/2024 concerning the incident with Resident #1 or note that Resident #2's RP had been notified of the incident. Review of Resident #2's care plan dated 4/3/2024 reflected Resident #2 had the Problem: Behavioral Symptoms: [Resident #2] disruptive behavior including taking other residents plates, wandering into other residents rooms, and touching other residents personal items. Interventions included convey acceptance of resident during periods of inappropriate behavior, encourage diversional activities, keep environment calm and relaxed, redirect as needed and remove from public area when behavior is unacceptable. During an interview on 6/26/2024 at 2:16 pm, Resident #2's RP stated he does not recall anyone telling him about the incident with Resident #2 and Resident #1 involving anything sexual or Resident #2 being in a room while Resident #1 was masturbating. RP stated the facility has been good about calling him if Resident #2 falls or wanders, or when he needs to know something about Resident #2 - but he does not remember anything like that of a sexual nature. RP stated he was concerned about this because he wondered if there could be other things he does not know that have happened with Resident #2 and he was not notified. During an interview on 6/26/2024 at 3:22 pm, LVN A stated she was working on 5/25/2024 when the incident with Resident #1 took place. She stated on 5/25/2024, Resident #1 was in his room, on his bed masturbating and had the curtain drawn. Resident #2 wandered into Resident #1's room and then laid down on the roommate's bed. Resident #1 did not alert staff and continued his sexual activity with himself. She stated she redirected Resident #2 out of the room and took her to her room. She stated Resident #2 is very confused and she had no way of knowing how or if this affected Resident #2. LVN A stated she thought she had charted in Resident #2's EMR about the incident with Resident #1. She stated she did not remember calling the RP for Resident #2, but she believed he had come up to the facility later that afternoon and she told him in person about the incident. She stated she thought she charted all of this but when she went back to look there was no progress note in Resident #2's chart about the incident or about her telling the RP. She stated in certain areas of the building they have problems with the computers saving and she wondered if that is what could have happened. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/2024 at 3:59 pm, the DON stated her expectation of the charge nurse after the incident would have been to complete documentation in the EMR and notify the RP. She stated she was not aware that there was no documentation in the EMR for Resident #2 about the incident or that the RP was not called. DON stated she did review Resident #2's EMR and did not see any documentation on the incident with Resident #1 or notification of the RP. She stated sometimes there were problems with computers saving and she has told staff to just restart the computer and chart again. During an interview on 6/27/2024 at 4:07 pm, the AD stated her expectation of documentation in Resident #2's EMR there should have been a progress note and RP should have been called. AD stated she had not checked the documentation, but her understanding was that it was not there. AD stated Resident #2 had rights and the RP has a right to know what is going on involving the resident. Review of facility policy Change in a Resident's Condition or Status dated 4/20/2023 revealed, Our facility promptly notifies the resident, his or her attending physician, health care provider and the resident representatives of changes in the resident medical/mental condition and/or status (e.g., change in level of care, billing/payments, resident rights, etc.)

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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 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** 44700 Based on interviews and record reviews the facility failed to implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs for one resident (Resident #1) of six (6) residents reviewed for care plans. The facility failed to ensure Resident #1's care plan was updated and revised to reflect inappropriate sexual behaviors towards staff. This failure placed residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in a decline in physical and psychosocial well-being. Findings included: Review of Resident #1's face sheet dated 6/26/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Mood Disorder, Diabetes mellitus (blood sugar regulation disorder), Alcohol abuse, Pulmonary hypertension (a type of hypertension that affects arteries in the lungs and heart) due to lung diseases, Atrial fibrillation (heart rhythm disorder involving the atria of the heart) and Ventricular fibrillation (heart rhythm disorder involving the ventricles of the heart). Review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 10 suggesting moderate cognitive impairment. Review of section E - Behavior reflected resident had not had any behaviors in the last 7 days related to hallucinations delusions, physical behaviors, verbal behaviors, wandering or rejection of care behaviors. Review of Resident #1's progress note dated 5/25/2024 by LVN A reflected Resident in room with penis out playing with self in front of another resident when staff came in to remove [sic Resident #2] he started yelling and cursing at staff to get out of room. Message left for family and [Nurse Practitioner] made aware. Review of Resident #1's progress note dated 5/26/2024 by LVN A reflected Resident remains on follow up for sexual behaviors this morning while this nurse was checking his blood sugar resident keep rubbing buttocks of this nurse and would not stop after being told to stop discussed appropriate behaviors then left room. Review of Resident #1's progress note dated 5/26/2024 by Nurse Practitioner reflected he is having increased sexual behaviors and masturbating in front of staff. Started medication today and will monitor for sexual aggression (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's current care plan dated 6/26/2024 reflected a problem: Behavioral Symptoms: [Resident #1] has a hx of going through roommates personal items and another problem: Behavioral Symptoms: Resident has a diagnosis of AMS and resides in the secured unit due to his wandering and poor safety awareness. Further review reflected no problems or interventions for inappropriate sexual behaviors. During an interview on 6/27/2024 at 3:59 pm, the DON stated she was aware of Resident #1's inappropriate sexual behaviors towards staff. She stated there was an incident on 5/25/2024 when Resident #1 was found masturbating in his room behind his curtain . She stated this incident was documented in the EMR and his care plan should have been updated. She stated it was the team's responsibility (DON, MDS Nurse , even the charge nurses) to update the care plan but ultimately it was her responsibility to ensure the care plan was updated. DON stated care plans are important because they tell nursing the problems residents have and the interventions to be used to address those problems. During second Interview on 6/27/2024 at 5:51 pm, the DON stated the care plan in the system for Resident #1 was the most recent and it had not been updated after his inappropriate sexual behaviors. During an interview on 6/27/2024 at 4:07 pm, the AD stated she was aware of the incident with Resident #1 being in his room masturbating when Resident #2 wandered in. She stated Resident #1's care plan should have been updated by either the MDS Nurse or the DON. She stated they had talked about it and thought it had been done. She stated the care plan is important because it tells how to take care of residents, how to provide care for resident. Needed to know how to provide care. A review of the facility policy Care Plans, Comprehensive Person-Centered dated December 2020 revealed a policy statement A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Further, the policy revealed 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.