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	01/22/2025

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50360 Based on record review and interviews, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one (1) of one resident reviewed for transfer and discharge rights. (Resident #2) The facility failed to plan for a safe discharge for Resident #2. This failure could place residents at risk for not receiving care and services to meet their needs upon discharge. Findings included: Review of Resident #2's Face Sheet dated 12/10/2024 reflected a [AGE] year-old male admitted [DATE] at 2:44 PM. with diagnoses of Unspecified Dementia (a general term for a decline in mental abilities that affects a person's daily life), Major depressive disorder with psychotic symptoms, Essential (Primary) Hypertension (abnormally high blood pressure that not caused by a medical condition), Pain, unspecified (pain that does not have a clear cause or diagnosis), and Major Depressive Disorder (persistent low mood and loss of interest in activities that people enjoy). Resident #2 was discharged on [DATE] at 10:17 AM. Record Review of the Medical Record was completed on 01/22/2025. These records were reviewed to assess the admission process. There was no MDS, Care Plan, Interdisciplinary Discharge Summary, or 30-Day Discharge Letter included in the Medical Record. During a phone interview on 01/22/2025 at 9:52 AM with the complainant, she stated Resident #2's was brought to the ER for a psychiatric evaluation by family member after leaving the nursing facility. The complainant contacted the NF and was told the NF would take Resident #2 back if he was appropriately medicated. The complainant stated Resident #2 was in the ER for 5 days awaiting placement and was placed at an alternative facility. During an interview on 01/22/2025 at 2:33 PM with the DON she reported the Ombudsman was notified of the discharge . (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the facility Administrator on 01/22/2025 at 2:37 PM she reported she was out on vacation at the time of the admission and discharge of Resident #2. Per her report based on her email chain of the situation, Resident #2 came from home after being seen by his primary care provider and was placed on the secure unit. The Interim DON in charge at the time spoke with family upon admission. Based on the email report, Resident #2 was getting acclimated then the next day Resident #2 was trying to get out the window. The Secure Unit Staff were unable to redirect the behavior of Resident #2. Resident #2 was placed on a one to one for elopement risk. The Administrator stated since Resident #2 had not been there for 30 days, the decision was made to discharge him to home . The Administrator confirmed this was a facility-initiated discharge. The Administrator reported she was not in the building and the IDON handled the discharge. Resident #2 was discharged to family. The Administrator reported the facility was contacted to see if Resident #2 could return. The staff at the NF informed the caller that the Resident would have to receive a new referral and assess to see if his needs could be met at the NF. During a phone interview on 01/22/2025 at 2:45 PM with Resident #2's family member, the family member stated staff from the NF called and told her she had to come pick up Resident #2 the day after admission. The caller stated they could not keep him. The family member stated the NF did not give any information on how to further care for Resident #2. The family member further stated she felt it was safe to take Resident #2 home because Resident #2s behavior was always pretty good with her. She reported she did not know what had transpired overnight at the NF. She stated Resident #2 is currently at another NF and was doing well. During an interview on 01/22/2025 at 2:56 PM, the Facility Liaison reported the resident was dropped off at the facility by a neighbor. Resident #2 was referred to the facility by his Primary Care Provider. The Facility Liaison reported Resident #2's family member refused to go with the resident to the secure unit upon admission and this set him off. The staff were struggling to trying to keep Resident #2 calm. Prior to admission, Resident #2's family member reported to the Facility Liaison Resident #2 could be combative. The Facility Liaison reported she went to visit Resident #2 while he was in the ER after he was discharged from the NF. She stated she encouraged Resident #2's family member to take the resident to the ER because more information was needed than what was provided by the resident's primary care provider. During an interview with the Corporate DON on 01/22/2025 at 4:25pm she stated the discharge was not implemented according to the policy of the organization. Record Review of the Medical Record on 01/22/2025 showed the record was lacking the Interdisciplinary Discharge Summary and Physician's orders for discharge. Review of facility's Discharge Summary and Plan policy reflected When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment.