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	07/11/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident received adequate supervision and assistive devices to prevent accidents for 1 of 3 residents (Resident #2).On 5/30/2025 at approx. 12:00 p.m., CNA D had been providing incontinent care to Resident #2. While care was being provided, the resident rolled off the bed onto the floor, hitting his face on the nightstand. Resident #2 sustained swelling and redness to the right side of his face, redness to his right knee, and required admission to the hospital on 5/30/25, for further treatment. A review of the care plan dated 5/20/20 reflected that Resident #2 required one-person assistance for bed mobility and transfers. And two-person assistance for ADL care.The noncompliance was identified as PNC. The IJ began on 05/30/25 and ended on 05/31/25 due to the in-services and CNA D had been suspended. The facility had corrected the noncompliance before the survey began. This failure resulted in resident #2 sustaining a femur fracture and hematoma.Findings included:A record review of Resident #2's face sheet reflected that he was a [AGE] year-old male admitted to the facility on [DATE]. He had been admitted with diagnoses including acute neurologic cerebral infarction, sepsis of an unspecified organ, dysphagia, cerebrovascular disease, chronic obstructive pulmonary disease, bipolar disorder, major depressive disorder, generalized muscle weakness, lack of coordination, and enterocolitis due to Clostridium difficile.A review of the MDS quarterly assessment dated [DATE] reflected a BIMS score of 6, indicating severe cognitive impairment. Section GG, which reflects functional abilities, indicated that Resident #2 required dependent, two-person assistance for showers, toileting, hygiene, and bed transfers. The MDS reflected prior to the incident resident #2 did not require a 2 person assist. A care plan dated 5/20/2025 reflected that Resident #2 required one-person assistance for bed mobility and transfers and two-person assistance for ADLs. Resident #2's care plan was updated after the incident to reflect the changes made to D/C the mattress.A record review of medical records dated 5/30/2025 reflected that Resident #2 had been admitted to the hospital with complaints of pain to his right knee and right cheek. The report stated that Resident #2 sustained an acute fracture of the right femur and a hematoma to the head without facial fracture.The record of doctors' orders reflected the doctor had put in an order for a low air mattress on 4/16/2025 for the resident and the resident denied wanting his mattress to be changed out. The doctor finally talked the resident into using the new mattress because it will help his wound heal and relieve the pressure. The day of the fall, the DON contacted the doctor and advised him of the fall and that the resident requested the mattress be taken off his bed and his old mattress be put back on and the doctor agreed to and D/C the low air mattress.An interview conducted on 6/24/2025 with Resident #2 revealed that he was not able to recall the incident.An interview on 6/24/2025 at 12:30 p.m. with CNA D who stated that on 5/30/2025 she had been providing incontinent care to Resident #2. She stated that while providing care, Resident #2 rolled off the bed, hitting his face and knee on the floor. CNA D reported that she immediately called for help, the nurse assessed Resident #2, and he was sent to the hospital. CNA D stated she had been employed at the facility since October 2024 and was not aware that Resident #2 was a two-person assist. She explained that she had always provided care to him alone. CNA D said she was suspended for one day after her shift ended at 2:00 p.m. She also stated that the Director of Nursing (DON) later informed her that Resident #2 was a two-person assist.An interview with the DON on 6/24/25 at 2:57pm revealed that she had not known whether CNA D was aware of the two-person assist requirement because the care plan and MDS conflicted-one stated one-person assist, while the other stated two-person assist. The DON explained that CNAs were responsible for reviewing a resident's care plan before providing care. She stated she had not been aware when the incident occurred. After the incident, the DON said she completed a return demonstration with CNA D for peri care and bed mobility when CNA D returned to work. The DON was uncertain whether CNA D had completed her shift before being suspended. She also reported that Resident #2 told her he had fallen out of bed.Interview with the Administrator dated 6/25/25 at 09:38am, who stated that she became aware of the fall around shift change at on 5/20/25 around 2:00 p.m. Resident #2 had been assessed by a nurse and immediately transferred to the hospital. The Administrator stated that CNA D was suspended pending investigation and returned to work on 6/1/2025 after being suspended on 5/31/2025. She explained it was her expectation that charge nurses ensure CNAs are aware of residents' care needs.A review of the facility's Fall Prevention Program policy, revised in November 2024, indicated that Each resident will be assessed for fall risk and will receive care and services in accordance with their

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interviews and record review the facility failed ensure residents were free of any significant medication errors for 1(resident # 1) of 6 reviewed for significant medication errors.The facility failed to ensure Resident #1 received his prescribed medications. According to residents' #1 MAR the missed medications are: Insulin glargine prescribed for diabetes, Lactulose prescribed for weakness, Allopurinol prescribed for hypertension, Clotrimazole prescribed for a disorder of the skin, Docusate sodium prescribed for obesity, fish oil prescribed for hyperlipidemia, Gabapentin prescribed for type 2 diabetes mellitus with foot ulcer, Rosuvastatin prescribed for hyperlipidemia, Tamsulosin prescribed for diabetes mellitus, and Valsartan prescribed for hypertension according to the physicians' orders on June 5, 2025 and June 6, 2025. Medication Technician #1 failed to ensure that resident #1 was free of a medication error.This deficit practice could place residents at risk of serious harm, up to and including death.Findings included:Based on the interviews and record review the facility failed ensure residents were free of any significant medication errors for 1(resident # 1) of 6 reviewed for significant medication errors. The facility failed to ensure Resident #1 received his prescribed medications. According to residents' #1 MAR the missed medications are: Insulin glargine prescribed for diabetes, Lactulose prescribed for weakness, Allopurinol prescribed for hypertension, Clotrimazole prescribed for a disorder of the skin, Docusate sodium prescribed for obesity, fish oil prescribed for hyperlipidemia, Gabapentin prescribed for type 2 diabetes mellitus with foot ulcer, Rosuvastatin prescribed for hyperlipidemia, Tamsulosin prescribed for diabetes mellitus, and Valsartan prescribed for hypertension according to the physicians' orders on June 5, 2025 and June 6, 2025. Medication Technician #1 failed to ensure that resident #1 was free of a medication error. This deficit practice could place residents at risk of serious harm, up to and including death.Findings included:A record review of Resident #1's face sheet dated on 6/24/25 reflected that a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had a medical history of acute osteomyelitis (a rapidly developing inflammation and infection of the bone, often caused by bacteria, that can lead to bone damage if not treated promptly), Diabetes mellitus due to underlying condition with other diabetic kidney complication (kidney disease (diabetic nephropathy) that develops as a consequence of diabetes caused by another underlying condition, and is characterized by specific kidney issues), Acute pain due to trauma (a sudden, intense pain that arises from an injury or physical damage, like a fall, car accident, or bone fracture), Essential hypertension (a condition characterized by persistently elevated blood pressure where no specific underlying medical cause can be identified), non-pressure chronic ulcer of part of right foot with necrosis of bone (a persistent open sore on the foot, specifically on the right foot, that is not caused by pressure, and involves the death of bone tissue (necrosis)), Disorder of the skin and subcutaneous tissue, unspecified (a skin or subcutaneous tissue disorder where the specific nature of the condition), Type 2 diabetes mellitus with foot ulcer (a situation where a person with type 2 diabetes develops a wound on their foot that doesn't heal properly), Hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), unspecified Sepsis in right foot, unspecified organism (Unspecified sepsis in the right foot with an unspecified organism means that the patient has a serious condition where their body's response to an infection is causing damage to its own tissues and organs, and the source of that infection is located in their right foot), Streptococcus (a type of bacteria that can cause skin, soft tissue and respiratory tract infections), Obesity (a chronic condition characterized by excessive accumulation of body fat that poses a risk to health). On 6/7/25, Resident #1 was discharged voluntarily due to him feeling that the facility had failed him by not providing prescribed medications. A record review for Resident's #1 care plan, was not able to be reviewed. Resident #1 was at the facility for two days; a care plan was not yet in place. A record review of Residents #1 MAR dated 6/7/2025, reflected that Insulin glargine, Lactulose, Allopurinol, Clotrimazole, Docusate sodium, fish oil, Gabapentin, Rosuvastatin, Tamsulosin, and Valsartan, where missed June 5th and June 6th, 2025. Next to the medications, the medication Technician noted that the medications were not in the facility. A record review of Residents #1 progress report dated 6/6/25 10:30pm reflected that resident c/o pain, tramadol had not come in. Hydrocodone 5/325 mg was delivered earlier 06/5/25, by the pharmacy. This medication was prescribed from Doctor #A. According to the progress note entered by Charge nurse A, notified the DON, the DON gave an okay to give Hydrocodone for pain, until the Tramadol could be delivered to the facility. Hydrocodone would be dc' d when Tramadol was delivered. On 6/6/25 at 8:03pm a progress note entered by Charge nurse A stated that Lantus, prescribed for diabetes, was given. A record review of