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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455489 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/29/2025 |
| NAME OF PROVIDER OR SUPPLIER Jeffrey Place Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for 4 (Resident #1, #2, #3, and #4) of 15 residents reviewed for accurate medical records. The facility failed to ensure the accuracy of Resident # 1, #2, #3 and # 4's, pain PRN narcotic drug record versus residents' eMARs for June and July 2025. The documentation between the two records did not match. This deficient practice could result in errors in care and treatment. Findings included: Review of Resident #1's face sheet, undated, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included myocardial infarction (a condition where blood flow to a part of the heart muscle is blocked, causing damage or death to that tissue), chronic obstructive pulmonary (a progressive lung disease characterized by airflow obstruction and breathing difficulties), anxiety disorder (a group of related conditions characterized by excessive and persistent fear or worry in situations that are not threatening), and schizoaffective disorder, depressive type (a mental illness characterized by a combination of symptoms from both schizophrenia (a severe, chronic brain disorder that affects how a person thinks, feels, and behaves)). Review of Resident #1's quarterly MDS assessment, dated 07/07/25, reflected a BIMS score of 05, indicating severe cognitive impairment. Section J - Health Conditions - Resident #1 received PRN pain medications or was offered or declined. Review of Resident #1's admission care plan reflected a problem start date of 02/18/17 category - Pain, Resident #1 was at risk for pain due to history of fracture and generalized osteoarthritis (a condition that causes the breakdown of cartilage in joints, leading to pain, stiffness, and swelling). Approach dated 07/26/21 administer medications as ordered and notify medical doctor if not effective. Review of Resident #1's medication orders reflected tramadol - Schedule IV (substances that have potential for abuse and dependence) tablet; 50 mg; amount to administer: 1 tab; oral, frequency Every 6 Hours - PRN, diagnosis - pain, start dated 10/13/2024 - open ended. Review of Resident #1's handwritten Narcotic Drug Record (provided for documentation, including route, date, time, and dose, of a narcotic administered to an individual patient/resident) for tramadol 50 mg tablet 1 tablet by mouth every 6 hours as needed revealed the tramadol 50 mg tablet reflected: 06/01/25 handwritten time illegible 1 tab. 06/05/25 handwritten time illegible 1 tab. 06/09/25 handwritten time illegible 1 tab. 06/11/25 time 4:00 pm 1 tab. 06/16/25 handwritten time illegible 1 tab. 06/19/25 handwritten time illegible 1 tab. 06/20/25 time 2:30 pm 1 tab. 06/21/25 time 6:30 pm 1 tab. 06/23/25 time 3:00 pm 1 tab. 06/26/25 handwritten time illegible 1 tab. 06/28/25 time 7:00 pm 1 tab. 07/03/25 time 2:00 pm 1 tab. 07/08/25 time 7:15 pm 1 tab. 07/11/25 time 2:45 pm 1 tab. 07/14/25 handwritten time illegible 1 tab. 07/18/25 handwritten time illegible 1 tab. 07/19/25 time 7:30 pm 1 tab. 07/20/25 handwritten time illegible 1 tab. 07/22/25 handwritten time illegible 1 tab. 07/22/25 handwritten time illegible 1 tab. 07/23/25 handwritten time illegible 1 tab. Record review of Resident #1's June 2025 MAR reflected no entries of tramadol - Schedule IV (substances that have a low potential for abuse and addiction compared to Schedule III drugs, but still have the potential for abuse and dependence) tablet; 50 mg; Amount to Administer: 1 tab; oral, frequency Every 6 Hours - PRN, diagnosis - pain, start dated 10/13/2024 - Open Ended administered to Resident #1. Record review of Resident #1's July 2025 MAR reflected tramadol - Schedule IV (substances that have a low potential for abuse and addiction compared to Schedule III drugs, but still have the potential for abuse and dependence) tablet; 50 mg; Amount to Administer: 1 tab; oral, frequency Every 6 Hours - PRN, diagnosis - pain, start dated 10/13/2024 - open ended administered to Resident #1 was administered on: 07/28/25 time 9:29 pm for PRN reason pain; pain before administered level 4 (moderated) PRN result effective. Review of Resident #2's face sheet, undated, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (usually caused by a stroke, is a condition characterized by paralysis (hemiplegia) or weakness (hemiparesis) on one side of the body), chronic obstructed pulmonary disease (a progressive lung disease that makes it difficult to breathe) and bipolar disorder (a mental health condition characterized by extreme mood swings, including emotional highs (mania or hypomania) and lows (depression)). Review of Resident #2's quarterly MDS assessment, dated 06/06/25, reflected a BIMS score of 06, indicating severe cognitive impairment. Section J - Health Conditions - Resident #2 received PRN pain medications or was offered or declined. Review of Resident #2's care plan reflected problem start date</p> | | |