STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676409	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Brazos of Waco	2430 Market Place Drive Waco, TX 76711

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/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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F 0627 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 interview and record review, the facility failed to permit Resident #1 to remain in the facility and failed to document the reason or notice of the discharge in the resident's medical record or implement policies to allow the resident to return to the facility upon discharge from the hospital for 1 of 1 resident reviewed for discharges (Resident #1).The facility failed to allow Resident #1 to return to the facility after his hospitalization. The facility failed to appropriately notify the resident, his representative, and the Long-term Care Ombudsman in writing of the discharge. This failure placed residents at risk of an extended, unnecessary hospitalization and a traumatic psychosocial adjustment to a new facility. Record review of Resident #1's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] and discharged [DATE] at 04:15 PM. The face sheet revealed his diagnoses were Metabolic Encephalopathy (brain function disrupted due to chemical imbalances), Gastric Reflux (acid from stomach backs up into the esophagus), prostate disease (range of medical conditions affecting the prostate gland), Parkinson's disease (a movement disorder of the nervous system), and Cognitive Communication Deficit (a group of disorders that affect the ability to communicate effectively). Record review of Resident #1's Initial MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated the resident's cognitive ability was moderately impaired and he required assistance with his activities of daily living. Record review of Resident #1's Care Plan, reflected a Focus area was initiated for Cognitive Loss / Dementia on 7/18/25 with a goal to meet the residents needs and maintain his dignity. Resident #1's interventions included to provide a quiet non-hurried environment free of distractions. In an interview on 7/30/25 at 9:30 AM, the ADM stated Resident #1 was sent to the ER on [DATE] for evaluation after he assaulted a staff member by blocking her in a chair and forcefully touching her in a sexual manner which was not his normal behavior. He stated neither the staff member or the resident was injured and neither required medical attention. ADM stated the police were not notified. He stated the hospital could not find any medical changes with the resident and they wanted to return the resident to the facility, but the facility refused on 7/25/25 to accept Resident #1 back. ADM stated the family, Ombudsman, and the Medical Director were notified but discharge paperwork was still being worked on. A record review on 7/30/25 at 2:00 PM of Resident #1's facility chart did not reflect a discharge noticeIn an interview on 7/30/25 at 5:00 PM, the BOM stated the normal discharge process was to issue a 30-day discharge notice. She stated this is important as it gives families time to find safe or alternate placement for the resident. If notices are not given, then something could happen to the resident to cause them harm. She stated she did not handle Resident #1's discharge. She stated she handled financial discharges, and the ADM handles the other types of discharges. In an interview on 7/30/25 at 5:25 PM, the DON stated the normal process for discharge was to follow the policy for safe discharge planning if the resident did not initiate the discharge. She stated they give a 30-day notice and help find an alternate place. She stated a discharge notice is the residents right and it is important to ensure resident is safe to go home and to prevent injury to the resident. She stated Resident #1 was not provided a discharge notice prior to his discharge on [DATE].In an interview on 7/30/25 at 5:44 PM, the ADM stated the normal policy for discharge is to give a 30-day discharge notice. He stated Resident #1's discharge paperwork was still in process and the resident was discharged without planning. He stated the purpose of the 30-day notice is to allow time for families to find placement needed to prevent an unsafe discharge which could lead to harm to a resident. A record review of the hospital Discharge summary dated [DATE] for Resident #1, reflected the resident was sent to the ER for out of character behavior on 7/25/25 and remained in the hospital until 7/29/25. The records reflected on 7/29/25 the resident was discharged to an alternate local nursing home with clinical notes reflecting he was stable with an unremarkable exam except for known Dementia Parkinson Disease with other behavioral disturbances. The discharge summary also reflected, the facility (nursing home) had declined to take him back and Patient would need placement at a different facility, as he could not live on his own.A record review of the facility policy titled, Social Services Policies and Programs-Discharge Notification dated 6/9/2023 reflected the following: Before a facility discharges a resident, the facility must notify the resident of the discharge and the reasons for the move in writing and in a language and manner they understand. The notice of discharge must be made by the facility at least 30 days before the resident is discharged . A copy of the discharge notice must be included in the resident's record.