

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER The Brazos of Waco		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>		

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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents are free of any significant medication errors for 1 of 6 residents (Resident #1) reviewed for significant medication errors in that Resident #1 's hospital Discharge summary dated [DATE] stated Stop taking Valacyclovir 1000mg. Resident #1 received 5 doses of Valacyclovir 1000mg after the medication had been discontinued, resulting in readmission to the hospital for altered mental status and metabolic encephalopathy due to Valacyclovir toxicity. The resident had been prescribed Valacyclovir for HSV Ophthalmicus (infection of the eye by Herpes Simplex Virus). The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 09/20/2025 and ended on 09/22/2025. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of serious outcomes such as overdose or death. Findings include: Record review of Resident #1's Face Sheet reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Acute and Subacute Infective Endocarditis (an infection of the inner lining of the heart (endocardium) and its valves.) Record review of Resident #1's Quarterly MDS, dated [DATE] reflected a BIMS of 15 meaning there is no or very little cognitive impairment. Record review of Resident #1's Care Plan, last updated 08/13/2025 reflected that Resident #1 required Hemodialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer able to do so. Record review of the hospital Discharge Instructions dated 09/20/2025 stated stop taking: Valacyclovir 1000mg tablet. Record review of the MAR for September 2025 indicated Resident #1 was administered 3 doses of Valacyclovir on 9/21/25 and 1 dose on 9/22/25. During an interview on 09/26/2025 at 10:47AM, the DON stated Resident #1 was originally admitted to the hospital for Metabolic Encephalopathy (a condition where the brain does not function properly due to an imbalance in the chemicals and nutrients that the brain needs to function normally) then returned to the facility on 9/20/2025. When Resident #1 returned the agency nurse admitted her to the facility and entered the medications per the discharge instructions from the Hospital. There was an order to discontinue the Valacyclovir, but the agency nurse failed to discontinue this medication. Upon learning of Resident 1's rehospitalization, the DON completed an audit of Resident #1's chart and discovered the error. The DON stated she contacted the agency nurse; however, the agency nurse merely stated she was unfamiliar with the version of the electronic medical record and offered no other explanation for the error. The DON stated they have a nurse reference book that describes how to manage orders. It also contained information for contacting members of the nursing management team if there were any questions regarding the management of medication orders. The DON stated they notified the agency of the need to discontinue services of this nurse. The DON stated that upon discovery of the error, a medication error report was completed, and the physician and responsible party were notified. The DON stated they held an Ad Hoc QAPI on 09/22/2025. During an interview with ADON D on 09/26/2025 at 11:25AM, the ADON stated she contacted the agency representative on 09/22/2025 at 2:43PM and reported the error and notified the representative that the agency nurse was not to return to the facility. Record review of the hospital admission records dated 09/22/2025 was due to Metabolic Encephalopathy (a condition in which the brain does not receive enough oxygen or nutrients leading to changes in brain function) due to Valacyclovir toxicity. During an interview on 09/26/2025 at 11:32AM, LVN A stated after breakfast on 09/21/2025, Resident #1's family member stated that Resident #1 was very confused and was not answering questions appropriately. Resident #1 was Spanish speaking only and LVN A was bilingual. LVN A stated she assessed Resident #1, and she had slurred speech and could not follow commands. LVN A stated she then notified the nurse practitioner who assessed Resident #1 and gave orders for transport to the hospital. Record review of the Facility Investigation Report dated 09/22/2025 indicated actions taken prior to entrance were: Medication error report completed with appropriate physician and responsible party notified. The nurse responsible for medication error suspended pending further investigation. Resident report roster was completed for the 30 days of facility admissions August 23, 2025, to September 22, 2025. These resident's hospital discharge orders were reviewed in comparison to the admitting orders entered into the electronic medical record and the Medication Reconciliation Report. There were no other errors found during the audit. Re-education of Administrative Nurses by Clinical Services Director on process of medication reconciliation with admission orders and confirmation of admission orders with physician. DON/Designee will re-educate staff nurses before nurse completes new admission or re-admission. Ad Hoc QAPI was held on 09/22/2025</p>		