STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675593	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisteria Place	3202 S Willis St Abilene, TX 79605

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 interview and record review, the facility failed to immediately notify the resident's physician when there was a significant change in the resident's physical status for 1 of 4 resident (Resident #1) reviewed for resident rights. The facility failed to notify the physician on [DATE] of a resident's change in condition of Resident #1's passing large amounts of watery fluids through his ileostomy and the resident expired on [DATE]. Resident #1's death certificate listed cause of death as Coronary Artery Thrombosis (blood clot). An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 3:40 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place the residents at risk of a delay in medical intervention, decline in health, serious injury, harm, impairment, or death. Findings include:Review of a Comprehensive assessment dated [DATE], revealed Resident #1 was an [AGE] year-old male, admitted to the facility on [DATE]. He had a primary diagnosis of [NAME] Syndrome (paralysis of colon - colon acts like it is blocked but nothing is blocking it). Additional diagnoses of ileostomy status (stoma of the small intestine), hypokalemia (low potassium in blood serum), atherosclerotic heart disease of native coronary artery without angina pectoris (the arteries supplying blood to the heart become narrowed due to the accumulation of plaque), congestive heart failure (the heart's ability to pump blood well). The resident had a BIMS score of 03 (severe cognitive impairment). A record review of Resident #1's Medication Administration Record revealed the resident received losartan potassium 25 mg for hypertension on [DATE] at 7:00 am. The physician order indicated to hold medication if systolic blood pressure was less than 120 and diastolic blood pressure was less than 70. Resident's #1 recorded blood pressure at the time of medication administration was 110/76 with a pulse of 100. The medication was given outside of the parameters. A record review of Resident #1's blood pressure revealed on [DATE] at 10:19 pm, Resident #1's blood pressure was 95/62 with a pulse of 100. Further review revealed there was no other documentation in the electronic record until 4:05 am. A record review of a progress note by LVN C dated [DATE] at 4:05 am, documented Resident #1 was found on the floor unresponsive and CPR initiated. EMS arrived at 4:20 pm and continued CPR. The resident was pronounced dead at 4:50 am. In an interview on [DATE] at 11:40 am, Resident #1's Family Member D said she visited Resident #1 every day. Family Member D said on [DATE] at 4:00 pm she visited Resident #1 and noticed he was breathing differently, looked pale and was weaker. She went and got Nurse A and expressed her concerns. At that time, Nurse A said Resident #1 had been having lots of fluids today in his ileostomy bag and it had to be changed several times already today. Resident #1 Family Member D requested Resident #1's vitals be taken. Nurse A took Resident #1's vitals which revealed a blood pressure of 98/50 with a pulse of 100. Nurse A said his blood pressure was low but not critical and he would be alright. Resident #1's Family Member D said she expressed concerns to Nurse A about the resident having the same symptoms in the hospital and he was dehydrated, and his potassium was low. Nurse A said she would get labs in the morning. Resident #1's Family Member D went and got the resident some Gatorade and then went home. She received a call on [DATE] at 5:00 am saying he had passed. In an interview on [DATE] at 11:55 am, Nurse A said Resident #1's Family Member D came and got her stating Resident #1's breathing was different, and he did not look good. Nurse A stated she told Resident #1's Family Member D that Resident #1 had lots of fluids that day (passing watery stools) and had to change his ostomy bag several times. She said she took his vital signs but could not remember them exactly, but his vitals were low but not extremely low. Nurse A said she did not see that his breathing was different, it was not labored, and he was talking to me and did not express any complaints. She said the resident passing lots of fluids was a new symptom for Resident #1 that had started on that day, [DATE] and had not had that symptom in the past. Resident #1's Family Member D asked about getting labs. Nurse A stated I told her I would get them in the morning. Nurse A was asked if she notified the doctor of the resident passing large amounts of fluids which was a different symptom for him, she said she could not recall if she did notify the doctor but did not see any documentation in the resident's chart when she looked in Resident #1's electronic record. When asked about the medication error, she said Resident #1 should not have received the Losartan due to his blood pressure outside of the parameters. When asked why the resident was given the medication, she said I don't know. In an interview on [DATE] at 12:25 pm, Physician B said the facility did not contact her concerning Resident #1 on [DATE]

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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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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 interview and record review the facility failed to ensure residents were free of significant medication errors for 1 of 5 residents (Resident #1) reviewed for medication errors in that: RN A gave Resident #1's blood pressure medication Losartan Potassium 25 mg needed for hypertension, outside of the ordered parameters. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medication by receiving too much or not enough. Findings Included: Record review of a Comprehensive assessment dated [DATE] revealed Resident #1 was an [AGE] year-old male, admitted to the facility on [DATE] and expired on [DATE]. He had a primary diagnosis of [NAME] Syndrome (paralysis of colon - colon acts like it is blocked but nothing is blocking it). Additional diagnoses included ileostomy status (stoma of the small intestine), hypokalemia (low potassium in blood serum), atherosclerotic heart disease of native coronary artery without angina pectoris (the arteries supplying blood to the heart become narrowed due to the accumulation of plaque), congestive heart failure (the heart's ability to pump blood well). The resident had a BIMS score of 03 (severe cognitive impairment). Record review on [DATE] of Resident #1's Physician's Order Summary Report, dated for active orders as of [DATE], revealed an order for Losartan Potassium 25 MG Tablet, Give 1 tablet by mouth one time a day for Hypertension, HOLD IF SBP IS LESS THAN 120 OR DBP LESS THAN 70. Start date of [DATE]. A record review on [DATE] of Resident #1 Medication Administration Record revealed the resident received losartan potassium 25 mg for hypertension on [DATE] at 7:00 am. The physician order instructed to hold medication if systolic blood pressure is less than 120 and diastolic blood pressure is less than 70. Resident's #1 recorded blood pressure at the time of medication administration was 110/76 with a pulse of 100. The medication was given outside of the parameters. Nurse A failed to notify the DON and Physician of a medication error. In an interview with Resident #1's Family Member D on [DATE] at 11:40 am, said they visited Resident #1 every day. On [DATE] at 4:00 pm Family Member D visited Resident #1 and noticed he was breathing differently, looked pale and was weaker. Family Member D went and got Nurse A and expressed their concerns. Family Member D requested Resident #1's vitals be taken. Nurse A took Resident #1's vitals which revealed a blood pressure of 98/50 with a pulse of 100. Nurse A said his blood pressure was low but not critical. A record review of Resident #1's blood pressures revealed on [DATE] at 10:19 pm, Resident #1's blood pressure was 95/62 with a pulse of 100. In an interview with Nurse A on [DATE] at 11:55 am, she said Resident #1's Family Member D came and got her stating Resident #1's breathing was different, and he didn't look good and requested his vitals be taken. She said she took his vital signs but could not remember them exactly, but his vitals were low but not extremely low. Nurse A said did not see that his breathing was different, it was not labored, and he was talking to me and did not express any complaints. When asked about the medication error, she said Resident #1 should not have received the Losartan due to his blood pressure outside of the parameters. When asked why the resident was given the medication, she said I don't know. In an interview with Physician B on [DATE] at 12:25 pm, she said the facility did not contact her concerning Resident #1 on [DATE]. She said she should have been contacted due to the resident's low blood pressure. She also said she was not notified of the medication error but did not think the medication error contributed to his death but could have been the reason his blood pressure was low on [DATE] when the nurse took it at 4:00 pm. In an interview with the DIT on [DATE] at 1:00 pm, she said she had not received any notification of Resident #1's medication error. She said a potential negative outcome of receiving blood pressure medications outside of the parameters would be the resident's blood pressure could bottom out. Record review of the facility policy Pharmacy Services: Medication Errors and Adverse Reactions, dated as revised 12/2019, revealed the following [in part]: Policy: It is the policy of the facility that medication errors and adverse drug reactions must be reported to the resident's attending physician.Procedures:1. Adverse drug reactions and medication errors with adverse clinical consequences must be reported to the resident's attending physician immediately. 5. The medical director, director of nursing services, and consultant pharmacist must be informed of all medication errors and adverse reactions.