

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675593	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Wisteria Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for accuracy and completeness. The facility failed to completely and accurately document Hydrocodone was being given to Resident #1 from 2/21/26 to 2/27/26. This deficient practice could put residents at risk of not receiving needed services. Findings include: Record review of Resident #1's detailed summary report/face sheet, dated 2/27/26, reflected a [AGE] year-old female who was admitted to facility on 2/18/26. Resident #1 had diagnoses which included Unilateral primary osteoarthritis-left knee (is the most common degenerative joint disease, caused by the gradual breakdown of protective cartilage that cushions joints, leading to pain, swelling, and reduced mobility), aftercare following joint replacement surgery-left knee, and anxiety disorder (a group of common, treatable mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that impairs daily functioning). Record review of Resident #1's Quarterly MDS, dated [DATE], reflected the BIMS score of 9, which indicated the resident was moderately cognitively impaired. Record review of Physician orders, dated 2/27/26, reflected Resident #1's HYDROcodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen), Give 1 tablet by mouth every 4 hours as needed for Moderate to Severe Pain (4-10). Record review of Resident #1's MAR, dated 2/27/26, reflected missing sign out dates for the hydrocodone medication from 2/21/26 through 2/27/26. Record review of Narcotics Sign out sheet, dated for the month of February 2026, indicated sign out dates with signatures and hydrocodone pill counts for the dates of 2/21/26 through 2/27/26. During an interview on 2/27/26 at 12:55 PM, Resident #1 stated she had not missed any of her hydrocodone medication. She stated the nurses made sure to get it to her anytime she needed it. She stated the pain was still high considering she just had knee replacement, but the facility did a good job of getting her pain medication. During an interview on 2/27/26 at 1:15 PM, the DON stated she had no idea why the MAR for Resident #1 was blank. She stated there must be an issue with the electronic tracking system. She stated because if the boxes were blank that indicated either the medication was not given or staff were not clicking out of the system. During an interview on 2/27/26 at 2:15 PM, RN A stated she had been working with Resident #1 on her pain everyday she worked because Resident #1 was on her hall. She stated every morning she would go down and ask Resident #1 her pain level and give Resident #1 her hydrocodone anytime she needed it following the physician order. She stated Resident #1 never refused her pain medications. She stated once Resident #1 indicated she needed her pain medication; she would go to the electronic system and pull the medication for Resident #1. She stated she would sign out the medication out of the narcotics sign out log for Resident #1. During an observation on 2/27/26 at 3:05 PM revealed RN A administer the medication of hydrocodone to Resident #1. RN A went to Resident #1 asked Resident #1's pain level. Resident #1 indicated a level 6. RN A went to the medication cart to pull hydrocodone for Resident #1. No infection control issues noted, medication was pulled, correct dosage was verified, and medication was given to Resident #1. RN A then signed out medication from (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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Narcotics document. During interview on 2/27/26 at 3:30 PM, the DON stated based on the previous MAR was blank and now the new stamp at 3:05 pm by RN A meant her nurses were not clicking the medication out of the electronic system. She stated this would be fixed. She stated this was important because this was the facility's way of tracking Resident #1 was receiving her pain medication. She stated without documentation being completed properly, Resident #1 could get to much or too little of her medications and possibly cause harm. Record review of new MAR dated 2.27.26 indicated that hydrocodone was administered to Resident #1 at 1504 by RN A. Record review of the facility's, undated, Policy titled: Controlled Medications-Storage and Reconciliation reflected:6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration. Amount administered. Signature of the nurse administering the dose, completed after the medication is actually administered.</p>		