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	05/20/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 3 (Resident #5) residents observed for oxygen management. The facility failed to post an oxygen in use sign indicating Resident #5 received oxygen.This failure could place residents at risk of receiving incorrect or inadequate oxygen support; decline in health; and at risk of fire hazards.Findings Included:Record review of Resident #5's electronic face sheet dated 05/19/2026 reflected an [AGE] year-old female with an admission date of 03/17/2026 and diagnosis including COPD (chronic respiratory disease that obstructs the airways and interferes with breathing).Record review of Resident #5's admission MDS, dated [DATE] reflected a BIMS score of 15 indicating the resident was cognitively intact. Further review of the MDS reflected Resident #5 utilized oxygen therapy continuous prior to admission and while she was a resident.Record review of Resident #5's comprehensive care plan, dated 03/20/2026, reflected Resident #5 had COPD with intervention that included give oxygen therapy as ordered by the physician. Record review of Resident #5's electronic physician orders, dated 03/17/2026 reflected an order for oxygen via nasal cannula at 1-4 LPM continuously to keep saturation greater than 92%. Record review of Resident #5's medical record, accessed on 05/19/2026, reflected resident did change rooms on 05/11/2026. During an observation and interview on 05/19/2026 at 11:00 a.m., Resident #5 was sitting in a wheelchair in her room. She was wearing a nasal cannula, and an oxygen concentrator was on administering oxygen at 2LPM. Resident #5 stated she had been on oxygen since she was admitted into the facility. There was no oxygen in use sign posted outside the residents' room. During an interview on 05/19/2026 at 11:17 a.m., LVN C stated there should have been an oxygen in use sign outside of Resident #5's room. LVN C stated the resident had moved rooms recently and the sign may not have gotten moved with her. LVN C stated she was responsible for making sure the residents with oxygen use had the oxygen in use sign outside of their rooms. She stated the DON monitored that the signs were outside of residents' room also. She stated the signs were to inform visitors and residents that there was oxygen in use in the room. She stated the facility was non-smoking so no one should have been smoking near the room no matter if there was a sign or not.During an interview on 05/19/2026 at 12:10 p.m., the DON stated best practice was for residents who used oxygen to have a sign outside of their room stating oxygen in use. She stated all staff were responsible for making sure those signs were present outside of the rooms of the residents who used oxygen. She stated she monitored that those signs were present. She stated Resident #5 had moved rooms on 05/11/2026 due to construction on another hall where her room was and the sign must have not been moved with her. The DON stated whoever moved her from the previous room should have moved the sign as well. She did not feel any negative impact would occur from the sign not being present due to the facility was a non-smoking facility. She stated in an emergency situation, staff or other emergency professionals would not be looking for those signs, and Resident #5 would not be in anymore danger than residents who did not utilize oxygen. She stated she would ask corporate if the facility had a policy on oxygen administration or oxygen in use signs. During a follow-up interview on 05/19/2026 at 2:45 p.m., the (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated the facility did not have a policy for oxygen administration or oxygen in use signs and the nurses would go off of orders for oxygen administration.During an interview on 05/20/2026 at 9:11 a.m., CNA A stated the nurses were responsible for making sure residents had an oxygen in use sign outside of their rooms when they used oxygen. She stated she did not have anything to do with those signs. She stated the signs were needed to let people know someone was wearing oxygen even though the facility was a non-smoking facility. She stated she would know to check on residents in an emergency who used oxygen to make sure the canisters were full or the concentrator was plugged into an outlet that the generator would supply electricity to if she saw an oxygen in use sign outside of their rooms.During an interview on 05/20/2026 at 10:15 a.m., the ADMN stated she expected for oxygen in use signs to be posted outside of residents rooms who used oxygen therapy. She stated the signs made sure everyone was aware of oxygen being in use inside of the room. She stated everyone who handles resident care was responsible for making sure the oxygen in use signs were posted. She stated nursing and department heads should be monitoring that those signs were posted during their weekly inspection of the resident room. She stated Resident #5 moved rooms on 05/11/2026 and she felt that the sign did not get moved with her. She stated she knew that prior to the move, Resident #5 had a sign posted outside of her room. She stated not having the sign could put residents at risk for any kind of hazard that could occur with oxygen including chemical reaction or smoking. She stated the signs were the first alert for people to be aware of the oxygen in use. At the time of exit on 05/20/2026 at 11:30 p.m., the facility did not provide a policy for oxygen administration or oxygen in use sign posting.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medical records were maintained on each resident that were complete and accurately documented for 1 of 6 (Resident #6) residents reviewed for accurate records. The facility failed to include oxygen administration on Resident #6's MAR. The facility failed to document oxygen saturation levels in the vital signs when oxygen utilized to keep saturation levels greater than 90% for Resident #6. These failures could place residents of an accurate depiction of care in the facility.Findings included: Record review of Resident #6's electronic face sheet, dated 05/19/2026, reflected an [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE]. Resident #6 had a diagnosis which included OSA (common sleep disorder where your airway becomes temporarily blocked during sleep, causing you to stop breathing for short periods) and pulmonary hypertension (high pressure in the arteries that carry blood from the heart to the lungs making the heart work harder and reducing oxygen flow to the body). Record review of Resident #6's quarterly MDS, dated [DATE], reflected a BIMS score of 05, which indicated severe cognitive impairment. Further review reflected Resident #6 used oxygen while a resident. Record review of Resident #6's comprehensive care plan, dated 12/03/2025, reflected Resident #6 had altered respiratory status and difficulty breathing related to OSA and pulmonary hypertension with interventions that included provide oxygen as ordered.monitor / document changes in orientation, increased restlessness, anxiety, and air hunger.monitor / document report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring. Record review of Resident #6's electronic physician order reflected an record by LVN B with start date of 01/17/2026 for O2 high flow, 6-10 LPM via nasal cannula PRN for SOB to maintain O2 saturation above 90%. Record review of Resident #6's MAR, May 2026, reflected no evidence that oxygen was being administered or oxygen saturation levels were being checked. Record review of Resident #6's progress notes for May 2026 reflected there was no oxygen saturation level recorded and the reason for administering the oxygen: 05/02/2026 at 1:47 a.m., Resident #6 remained on high flow O2 at 6 LPM via nasal cannula. 05/02/2026 at 2:56 p.m., Resident #6 was on 3 LPM on high flow via nasal cannula. 05/03/2026 at 2:22 a.m., Resident #6 remained on high flow O2 at 6 LPM via nasal cannula. 05/03/2026 at 12:51 p.m., Resident #6 was on 3 LPM on high flow via nasal cannula. 05/04/2026 at 2:16 a.m., Resident #6 remained on high flow O2 at 6 LPM via nasal cannula. 05/05/2026 at 12:11 p.m., Resident #6 was on 3 LPM on high flow via nasal cannula. 05/06/2026 at 12:12 a.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/06/2026 at 4:37 p.m., Resident #6 was on 3 LPM on high flow via nasal cannula. 05/07/2026 at 1:24 a.m., Resident #6 was on 3 LPM on high flow via nasal cannula. 05/08/2026 at 1:16 a.m., Resident #6 remained on high flow O2 at 6 LPM via nasal cannula. 05/08/2026 at 11:55 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/09/2026 at 4:32 p.m., Resident #6 was on O2 at 3 LPM via nasal cannula. 05/09/2026 at 11:56 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/10/2026 at 11:58 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/11/2026 at 11:00 p.m., Resident #6 remained on high flow O2 at 5 LPM via nasal cannula. 05/12/2026 at 4:58 a.m., Resident #6 remained on high flow O2 at 5 LPM via nasal cannula. 05/12/2026 at 1:25 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/13/2026 at 3:19 a.m., Resident #6 remained on high flow O2 at 5 LPM via nasal cannula 05/13/2026 at 11:43 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/14/2026 at 5:24 p.m., Resident #6 was on O2 at 3 LPM via nasal cannula. 05/14/2026 at 11:52 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/15/2026 at 1:40 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/16/2026 at 3:03 a.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/16/2026 at 1:33 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/17/2026 at 2:18 a.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/17/2026 at 11:46 a.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/18/2026 at 2:25 p.m., Resident #6 was on O2 at 3 LPM via nasal cannula. 05/18/2026 at 11:39 p.m., Resident #6 was on high flow O2 at 6 LPM via nasal cannula. 05/19/2026 at 2:29 p.m., Resident #6 was on O2 at 3 LPM via nasal cannula. Record review of Resident #6's vital signs records in May 1st - May 19th 2026 reflected oxygen saturation level was recorded only on the following dates: 05/02/2026 at 2:05 p.m. 98% with oxygen being administered. 05/07/2026 at 10:21 a.m. 95% with oxygen being administered. 05/09/2026 at 10:26 a.m. 97% on room air. 05/10/2026 at 9:32 a.m. 96% on room air. 05/14/2026 at 9:49 a.m. 96% on room air. 05/16/2026 at 9:02 a.m. 95% with oxygen being administered. 05/18/2026 at 9:01 a.m. 92% on room air. 05/19/2026 at 9:09 a.m. 97% on room air. During an interview on 05/20/2026 at 8:55 a.m., LVN B stated she checked on Resident #6 every two hours and took her oxygen saturation level during those checks. LVN B stated she documented saturation level in the MAR when she obtained the oxygen saturation levels. She stated she obtained Resident # 6's oxygen saturation this morning before breakfast and showed where she wrote it down on a paper document. She had Resident #6's oxygen saturation was 97% on 3 LPM canister. She stated when Resident #6 used the canister she got 3 LPM and when she used the concentrator, she got 6 LPM. She stated she had not documented the oxygen saturation in the system yet. She did not know why there were days without any readings being documented for Resident #6. She stated she was unsure if she was supposed to do something in the physician orders when she obtained them to populate the saturation and or reason the resident was put on PRN oxygen. She stated PRN meant that Resident #6 did not need oxygen all the time. She stated she had gotten the order from the hospice provider and had put it into the electronic medical record as it was given to her. She did not know if anyone monitored the oxygen saturation levels or reason why oxygen was administered. She stated she would have to ask the DON who was responsible for putting something in the order to make it show on the MAR. She verified that Resident #6's MAR did not have a space for oxygen saturation or oxygen orders.During an interview on 05/20/2026 at 9:16 a.m., the DON stated she expected for all residents to have their vital signs checked once a day on the day shift. She stated that if a resident was on PRN oxygen, she expected for the MAR to have a place for the oxygen saturation level or SOB symptoms to be documented. She stated she reviewed the new orders by running a report and then made sure the orders were transferred onto the MAR as needed. She stated she had missed that Resident #6's orders for PRN oxygen did not have a spot on the MAR for oxygen saturations or SOB symptoms to be documented. She stated if the nurses did not document symptoms or oxygen saturation levels on the MAR, she expected for them to document in the progress notes. She stated she did not have a time frame for when the nurse should document the symptoms and oxygen saturation levels but that they should document be the end of the nurses shift. She stated she did not monitor the documentation in the computer system but she did ask the nurses during morning verbal rounds about resident vital signs. She stated she had not noticed that there were days when the documentation did not occur for Resident #6. She stated she could not verify that the vital signs were taken on those days but she stated they should have been documented in the vital sign section of the medical record if they were taken. She stated giving a resident oxygen when they did not need it per physician orders could cause CO2 retention that could lead to the resident not wanting to breath. During an interview on 05/20/2026 at 10:15 a.m., the ADMN stated her expectation would be for the nurses to document whatever they did in the medical record. She stated if the symptoms or oxygen saturation was not documented, then there was no way to prove it was don. She stated she would defer to the DON for specific order questions and in-service questions on oxygen administration.Review of facility policy, titled Licensed Nurse Procedures: Clinical Documentation, no date, reflected Services provided to the resident's changes in their residence condition shall be documented in the residence medical record. Procedure: 1. Medications administered should be documented in the resident's clinical records. 2. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Incidents, accidents, or changes in the residents' condition should be documented. 3. Documentation of treatments shall be documented in the clinical record.