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	06/26/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interviews and record review, the facility failed to ensure the development of comprehensive care plan that meets allof a residnt's need for 1 of 18 residents (Resident #37) reviewed for advance directives. The facility failed to ensure that Resident #37's advanced directive preference was included in care plan or stored in DNR binder at the nurses' station. The facility failed to have the advanced directive in the binder and failed to implement their policies for implementing advance directives This failure could place residents at risk of receiving treatments that go against their personal preferences and does not allow them to make an informed decision about their care. Finding included: Record review of the Resident #37's face sheet dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: cerebral infarction stroke), presence of cardiac pacemaker, and metabolic encephalopathy (brain swelling). Further investigation of face sheet revealed that resident resided on unit 3 (300 hall). Record review of Resident #37's admission MDS dated [DATE] revealed: no BIMS score, and Resident #37 was rarely or never understood. Record review of Resident #37's care plan dated [DATE] revealed no evidence of advanced directive code status. Record review of Resident #37's electronic physician orders dated [DATE] revealed DNR-DO NOT RESUSCITATE. Record review of Resident #37's OOH-DNR dated [DATE] revealed adult child signed and dated form, two witnesses signed form, and physician signed form. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:49 PM, the DON stated the facility ensures direct care nurses are notified of resident's code status by locating information in DNR binder. She stated the facility does not add code status to resident's care plans. During an observation on [DATE] at 2:58 PM, DNR binder observed at nurses' station for 300 hall and no information about Resident #37's advanced directive wishes observed inside of binder. During an interview on [DATE] at 3:08 PM, RN B stated direct care staff would look in the DNR binder at nurses' station to see if resident had a DNR code status. She stated nurses' station on 400 halls housed DNR binder for residents that resided on 400 hall and nurses' station on 300 halls housed DNR binder for residents that resided on 300 hall of nursing facility. During an interview on [DATE] at 3:20 PM, LVN C stated typically residents DNR status would be identified on admission by the admission nurse. She stated admission nurse was responsible for placing resident's information in DNR binder at nurses' station. She stated she did not know why Resident #37's information was not in DNR binder on 300 halls. She stated Resident #37 was admitted on [DATE] and her DNR status should have been placed in DNR binder. During a follow up interview on [DATE] at 3:26 PM, the DON stated she expected for a resident that was a DNR to be identified by admission nurse on admission and the admission nurse should add resident's information to DNR binder at nurses' station. She stated nurses monitor code status information by performing chart audits including ADON and DON. She did not know why Resident #37's information was not in DNR binder or why is had not been identified prior to [DATE]. She stated the effect of information being left out of the binder could lead to delay of resuscitation. She stated nurses could look into electronic medical record to see information on code status as well. During an interview on [DATE] at 4:03 PM, the ADMN stated her expectation was for DNR binders to be updated when a change in code status occurred. She stated she expected facility policy to be followed. She stated the facility policy stated social worker or designee would monitor advanced directive information in DNR binders at nurses' stations were up to date. She stated she did not know why information was not present in DNR binder for Resident #37. She stated the effect of not having information in the DNR binder could potentially lead to advanced directive not being followed in an emergency. During a phone interview on [DATE] at 4:20 PM, Resident #37's son stated he expected the facility to follow their advanced directive wishes. He stated he expected for her wishes to be honored and no CPR to be performed. Record Review of facility policy titled Code Status Listing revised date ,d+[DATE] revealed: 1. All residents will be informed of their opportunity to file advanced directives upon admission and at least annually. 2. The residents with code status will be kept in a binder at each nurse's station. 3. Social Serviced, or designee, will keep the code status list current and updated whenever a change occurs. 4. ID team will discuss advanced directives with resident/responsible party during annual care plan conference and update as necessary.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558 Based on observations, interviews, and record review, the facility failed to ensure no expired medication/treatment products were not on 1 of 1 Treatment cart reviewed for medication storage. The facility failed to remove expired box of collagen dated ,d+[DATE] from treatment cart. This failure could result in delayed healing of wound. Findings included: During an observation on [DATE] at 1:00 PM wound treatment supplies and products being set up for a treatment, LVN A observed expired box of collagen (a protein in the body that encourages wounds to heal quickly and effectively) sheets. The expiration date: ,d+[DATE]. During an interview on [DATE] at 1:01 PM LVN A stated the expired supplies should not have been left on the cart. She stated that using expired wound care products (collagen sheet) could have caused the treatment to not be as effective due to the matrix of product. She stated she did not know why expired collagen was on the cart. LVN A stated she had checked the cart earlier in the day but did not see that this dressing was expired at that time. During an interview on [DATE] at 1:50 PM the DON stated her expectations was expired treatment products should not have been applied to resident, and the treatment nurse should have checked expiration dates prior to using and discard any expired products immediately. The DON stated the treatment nurse audits their cart weekly and nursing management monitors as well. She stated treatment products were to promote healing and if expired product was used it could have interfered with the healing process and could have delayed healing of resident wound. She stated she did not know what had caused the failure. During an interview on [DATE] at 2:15 PM the ADMN stated the expectation would have been that treatment products or medications were used on/or before the expiration date. She stated it was the responsibility of treatment nurse to ensure products and medications were not expired and should have been double checked by nursing management. She stated possible harm to the resident could have been the potency of treatment could have been decreased if not used prior to or by the expiration date. She stated the facility had been training new staff on wound care and it could have possibly been missed due to this. Record review of facility's policy titled, Care and Treatment Subject: Medication Access and Storage, dated , d+[DATE] revealed: 13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists.

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F 0867 Level of Harm - Potential for minimal harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44558 Based on interviews, record reviews the facility failed to ensure that the quality assessment and assurance committee developed and implemented appropriate plans of actions to correct deficiency of having a full time Social Worker on staff for Residents social needs for all resident. The facility failed to ensure the QAPI committee, which included the Administrator, DON, Medical Director, had followed the facility's plan of correction dated 04/12/2023. This failure could place all residents at risk for unmet social services and psychosocial needs. Findings included: Review of the facility's CMS 2567/facility-submitted Plan Of Correction (POC) dated 05/05/2023 which was submitted in response to the 04/12/2023 SSA recertification survey revealed Facility has contracted a licensed social worker who is licensed by the Texas State Board of Social Worker Examiners to oversee work of social services designee . Facility has contracted a licensed social worker to assist in meeting the needs of residents. Completion Date 05/15/23. Record review of Social Services Manager's employee file revealed Social Services Manager was not a licensed social worker. During an interview on 06/26/24 at 3:30 PM the ADMN stated the Social Services Manager had a Bachelor of Arts degree in Human Services. The ADMN stated she had an interview with licensed social worker approximately one year ago and candidate declined due to not wanting to relocate. The ADMN stated she did not feel that any resident had been harmed or denied any services that a Licensed Social Worker could have provided. The ADMN stated the facility discussed the POC from 04/12/2023 at every monthly QAPI meeting. The ADMN stated she felt that she had followed the POC actions. She stated she considered the QAPI Plan was the policy that facility had for QAPI. Per review of facility's QAPI Plan on 06/26/2024 at 3:45 PM revealed: c. To serve the whole facility: The resident, resident's family, caregiver, employee, and other service providers all working towards a common goal of providing the best care possible. B. Core Values: a. Celebration: Celebrate successes and make work fun b. Accountability: Being held to highest standards of care and Professionalism c. Passion for Learning: On-going training d. Love One Another: Strive to treat each other as we would our Family. (continued on next page)

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F 0867 Level of Harm - Potential for minimal harm Residents Affected - Many	e. Intelligent Risk Taking: Trusting each other's judgment. f. Customer Second, We put our employee's first g. Ownership: We reward and support our employees who treat this facility as if they owned it. C. Guiding Principles pertaining to quality assurance and performance improvement. a. Guiding Principle #1: The use of QAPI will be prominent in how we manage our operation on a daily basis b. Guiding Principle #2: The facility will use QAPI to assist us in making. decisions for improvement in the facility and facility functions in order to guide our day-to-day operations c. Guiding Principle #3: QAPI will be at the core for all resident care to help ensure the residents receive quality of care. d. Guiding Principle #4: QAPI includes all of our employees, all departments and all services provided. e. Guiding Principle #5: QAPI in this facility focuses on systems and processes and the improvement in those systems and processes when a flaw is discovered. The QAPI plan for this facility helps us to provide guidance for overall quality improvement in our care. Decisions will be made based on the QAPI that will help to improve quality of care, quality of life, resident choice, person directed care and resident transitions. The Executive Director will assure that the QAPI plan is reviewed on an annual basis by the QA committee. Revisions will be made based on on-going assessment of resident needs and as the need arises to help to reestablish good quality care. QAPI activities will be integrated across all the care and services of our facility. Each discipline will have a representative on the QAA committee. A facility assessment will be conducted to include an overview of the services and care areas that are provided. Any new service areas or changes in population or service areas identified during the facility assessment will be included in our QAPI plan. [Facility] current care areas: The QAA committee includes the executive director, director of nursing, infection control officer, medical director, dietary director, rehabilitation director, social worker, activities director, plant operations manager, assistant director of nursing, MDS director, housekeeping/laundry supervisor, business office manager, central supply and a CNA. The QAA committee will meet monthly. The committee will monitor progress, provide input, and ensure the individuals involved in the project have the resources they need. (continued on next page)

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F 0867 Level of Harm - Potential for minimal harm Residents Affected - Many	QAPI activities and outcomes will be shared with staff at staff meetings and with residents through the resident council meetings at least quarterly. Quality Improvement Projects (QITS) are implemented in accordance with CMS regulations regarding PIPs. PIPs are developed when there is a problem identified and needs a solution to the problem. The PIP implemented is reviewed during the QAPI meetings with the medical director.