

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 07/30/2025
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)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the residents' medical symptoms for 3 (Resident #7, Resident #8, and Resident #77) of 18 residents reviewed for unnecessary medications. The facility failed to ensure Resident #7's PRN Alprazolam (medicine used to treat the symptoms of anxiety) was discontinued after 14 days or document a rationale for the continued provision of the medication. The facility failed to ensure Resident #8's PRN Xanax (Alprazolam) (medicine used to treat the symptoms of anxiety) was discontinued after 14 days or document a rationale for the continued provision of the medication. The facility failed to ensure Resident #77's PRN Lorazepam (medicine used to treat the symptoms of anxiety) was discontinued after 14 days or document a rationale for the continued provision of the medication. This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications. Findings included: Resident #7 Review of Resident #7's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: anxiety, delusional disorders, and psychosis. Review of Resident #7's quarterly MDS assessment dated [DATE], revealed a BIMS score was not completed. Review of Section N: Medications revealed Resident #7 was receiving anti-anxiety medications. Review of Resident #7's Comprehensive Care Plan revised on 06/25/2025, revealed: Focus: Resident has anti-anxiety medication use r/t anxiety, agitation, and restlessness .Interventions: Give anti-anxiety medication ordered by physician, monitor/document side effects and effectiveness. Review of Resident #7's electronic Physicians Orders revealed: Alprazolam Oral Tablet 0.5 mg Give 1 tablet by mouth every 6 hours as needed for Anxiety, start date 03/06/2025 with no stop date. Review of Resident #7's July 2025 MAR revealed a dose of Alprazolam was administered on 07/10/2025 at 3:31 pm. Review of Resident #7's June 2025 MAR revealed no doses of Alprazolam were administered. Review of Resident #7's physician progress notes revealed no evidence of documented rationale to order PRN Alprazolam for more than 14 days. Review of Drugs.com for Xanax/ Alprazolam accessed on 07/30/2025 at https://www.drugs.com/xanax.html revealed: Xanax is used to treat anxiety disorders and anxiety caused by depression. Xanax can slow or stop your breathing, especially if you have recently used an opioid medication or alcohol. Resident #8 Review of Resident #8's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: fractured leg, liver disease, and heart failure. Review of Resident #8's significant change MDS assessment dated [DATE], revealed a BIMS score of 00 which indicated severe cognitive impairment. Review of Section N: Medications revealed Resident #8 was not receiving anti-anxiety medications. Review of Resident #8's Comprehensive Care Plan revised on 06/21/2025, revealed: Focus: Resident has anti-anxiety medication use r/t anxiety, agitation, and restlessness .Interventions: Give anti-anxiety medication- Xanax ordered by physician, monitor/document side effects and effectiveness. Review of Resident #8's electronic Physicians Orders revealed: Xanax Oral Tablet 0.25 mg Give 1 tablet by mouth every 12 hours as needed for Anxiety, start date 07/09/2025 with no stop date. Review of Resident #8's July 2025 MAR revealed (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 - Some	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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and describes the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 of 18 residents (Resident #68, Resident #07, Resident #65, Resident #30) reviewed for comprehensive person-centered care plans. The facility failed to develop a comprehensive care plan for Resident #68, Resident #07, Resident #65, and Resident #30 that included advance directive information. This deficient practice could place residents in the facility at risk of not being provided the necessary care or services and not having a personalized plan of care developed to address their specific needs. The findings include: Resident #68 Record review of Resident #68's Face sheet, dated [DATE], revealed an [AGE] year-old female, with an admission date into the facility of [DATE]. Resident #68's diagnoses included Metabolic Encephalopathy (a condition where brain function is disrupted due to chemical imbalances in the body, often resulting from illnesses or organ dysfunction) and Acute Kidney Failure (a sudden and rapid decrease in kidney function). Record review of Resident #68's Annual MDS, dated [DATE], revealed Resident #68's BIMS score was 10, which indicated moderate impairment. Record review of Resident #68's doctor orders, dated [DATE], revealed Resident #68 had standing orders of, Full Code: Use AED (Automated External Defibrillator) with CPR during sudden cardiac arrest. Record review of Resident #68's Care Plan, with recent review of [DATE], revealed the information in the area of advance directives and Resident #68's desire to be resuscitated in the event of sudden cardiac arrest was not included in Resident #68's care plan. During an interview on [DATE] at 9:56 a.m., Resident #68 said if she had a heart attack, Resident #68 wanted the staff to do everything they could to keep her alive. Resident #68 said she had not discussed the decision during her care plan meeting that she could remember. Resident #07 Record review of Resident #07's Face sheet, dated [DATE], revealed a [AGE] year-old female, with an admission date into the facility of [DATE]. Resident #07's diagnoses included Unspecified Atrial Fibrillation (a common heart condition where the heart's upper chambers beat irregularly and often too fast disrupting the normal heart rhythm), Cognitive Communication Deficit (difficulties in communication that arise from impairments in cognitive processes rather than problems with speech or language), and Delusional Disorders (a mental illness characterized by one or more delusions lasting for at least one month without other prominent psychotic symptoms like hallucinations or disorganized thinking). Record review of Resident #07's Quarterly MDS, dated [DATE], revealed Resident #07's BIMS score was not calculated. Section C0100, Should Brief Interview for Mental Status (C0200 - C0500) be Conducted was left blank. Record review of Resident #07's doctor orders, dated [DATE], revealed Resident #07 had standing orders of, Full Code: Use AED (Automated External Defibrillator) with CPR during sudden cardiac arrest. Record review of Resident #07's Care Plan, with recent review of [DATE], revealed the information in the area of advance directives and Resident #07's desire to be resuscitated in the event of sudden cardiac arrest was not included in Resident #07's care plan. During an interview on [DATE] at 10:11 a.m., Resident #07 said she wanted the staff at the facility to perform CPR on her because she did not want to die. Resident #07 was unable to state if the choice was discussed at her care plan meeting. Resident #65 Record review of Resident #65's Face sheet, dated [DATE], revealed an [AGE] year-old female, with an admission date into the facility of [DATE]. Resident #65's diagnoses included Parkinson's Disease (a progressive neurodegenerative disorder that primarily affects movement), and Dementia (a broad term for a decline in mental ability severe enough to interfere with daily life), moderate, with psychotic (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disturbance. Record review of Resident #65's Quarterly MDS, dated [DATE], revealed Resident #65's BIMS score was not calculated. Section C0100, Should Brief Interview for Mental Status (C0200 - C0500) be Conducted was coded 0 for No - resident was rarely/never understood; therefore, BIMS score was not determined. Record review of Resident #65's doctor orders, dated [DATE], revealed Resident #65 had a standing order of, DNR - Do Not Resuscitate. Record review of Resident #65's Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order, dated and notarized [DATE], revealed Resident #65 had a DNR in place to be used as needed prior to admission into the facility on [DATE]. Record review of Resident #65's Care Plan, with recent review of [DATE], revealed the information in the area of advance directives and Resident #65's presence of a formal DNR was not included in Resident #65's care plan. During an observation on [DATE] at 10:21 a.m., Resident #65 was observed as she sat in her wheelchair in the common area of the facility. She was observed to be unable to respond to interview questions. Resident #30 Record review of Resident #30's Facesheet, dated [DATE], revealed a [AGE] year-old male, with an admission date into the facility of [DATE]. Resident #30's diagnoses included Heart Failure (the heart cannot pump enough blood to meet the body's needs, not that it stopped beating), unspecified and Unspecified Dementia (a broad term for a decline in mental ability severe enough to interfere with daily life) without behavioral disturbance. Record review of Resident #30's Quarterly MDS, dated [DATE], revealed Resident #30's BIMS score was not calculated. Section C0100, Should Brief Interview for Mental Status (C0200 - C0500) be Conducted was left blank. Record review of Resident #30's doctor orders, dated [DATE], revealed Resident #30 had a standing order of, DNR - Do Not Resuscitate. Record review of Resident #30's Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order, dated and notarized [DATE], revealed Resident #30 had a DNR in place to be used as needed. Record review of Resident #30's Care Plan, with recent review of [DATE], revealed the information in the area of advance directives and Resident #30's presence of a formal DNR was not included in Resident #30's care plan. During an interview on [DATE] at 11:00 a.m., Resident #30 said his advance directive was not discussed during his care plan meeting. Resident #30 said he discussed his signed DNR when he first came into the nursing facility. During an interview on [DATE] at 2:28 p.m., the MDS Coordinator said the advance directives were not required to be in the care plans. The MDS Coordinator said he would consider the information and decision making involved in the advance directives as a major importance to a person and their rights. The MDS Coordinator said the information involved during the discussion of advance directives would be good information to have in the resident's care plans. The MDS Coordinator said at admission, the facility discussed the residents' preference in the area of advance directives and anything that might warrant further discussion. The MDS Coordinator said he could see the benefits of discussing advance directives during the care plan meetings especially to ensure the residents' rights were not violated. During an interview on [DATE] at 3:00 p.m., the Operations Manager said the advance directives were not part of the care planning because the process was not required. The Operations Manager said the residents' status was kept in a binder at the nurses' station and updated as needed. During an interview on [DATE] at 3:41 p.m., the DON said advance directives were not required to be care planned and she did not think the information should be in the residents' care plan. The DON said the code status was not on the hospital discharge paperwork as an order and did not become an order upon admission if the resident was unable to produce documentation that a DNR was in place. Record review of the facility's policy, Comprehensive Person-Centered Care Planning, dated 01/2022, revealed, 4. The facility IDT would develop and implement a comprehensive person-centered care plan for each resident and will include resident's needs identified in the comprehensive assessment and resident's goals and desired outcomes, preferences for future discharge and discharge plans. 5. The resident has the right to refuse or discontinue treatment. In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk. Record review of the facility's policy, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Rights, Code Status Listing, dated 11/2007, revealed, IDT team will discuss advanced directives with resident/responsible party during annual care plan conference.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure kitchen staff used proper hand washing and sanitation procedures when handling and serving food. These failures could place residents who received food from the kitchen at risk of cross contamination and food borne illness. The findings include: During an observation on 07/28/2025 at 11:05 a.m., [NAME] E, who was wearing gloves, put a pair of oven mitts on and removed a pan of oven cooked chicken from the oven. [NAME] E removed the oven mitts and picked up and placed a thermometer into a piece of chicken. [NAME] E covered the pan of chicken with tin foil, put the oven mitts on and placed the pan into the oven. [NAME] E was observed as he removed a pan of spinach from the oven and placed it on the prep table. [NAME] E removed the oven mitts and picked up and placed a thermometer into the spinach. [NAME] E covered the pan of spinach, put the oven mitts on and placed the pan into the oven. [NAME] E was observed as he removed a pan of mashed potatoes from the oven and placed it on the prep table. [NAME] E removed the oven mitts and picked up and placed a thermometer into the mashed potatoes. [NAME] E covered the pan of mashed potatoes, put the oven mitts on and placed the pan into the oven. [NAME] E did not change gloves or wash his hands prior to donning or doffing the oven mitts. During an observation on 07/28/2025 at 11:19 a.m., the Assistant Dietary Supervisor, who was wearing gloves, was observed as she picked up a spoon by the eating surface and placed it on a cloth napkin. The Assistant Dietary Supervisor proceeded to pick up a knife by the blade end and a fork by the tines. The Assistant Dietary Supervisor rolled the silverware up in the napkin and placed it in a bin. The Assistant Dietary Supervisor laid a napkin on the table and picked up another spoon by the eating surface, a knife by the blade end, and fork by the tines and placed them on the napkin. The Assistant Dietary Supervisor rolled the napkin and placed it in the bin. The Assistant Dietary Supervisor was observed as she rubbed the side of her nose with her right hand and the placed a napkin on the table. The Assistant Dietary Supervisor picked up a knife by the blade end, a spoon by eating end, and a fork by the tines and placed them on the napkin. The Assistant Dietary Supervisor did not change her gloves or wash her hands during the observation. During an observation on 07/28/2025 at 11:26 a.m., Dietary Aide G was observed to exit the kitchen by the back exit door and enter the storage refrigerator/freezer unit located in the outside area behind the kitchen. Dietary Aide G entered the storage unit, retrieved the dessert premade for lunch, exited the unit, and reentered the kitchen by the back door. Dietary Aide G picked up the pan with his hands that had not been washed. Dietary Aide G placed the pan on the prep table and immediately began placing small bowls on a serving tray. Dietary Aide G retrieved a serving scoop with his bare hands and began to put the dessert in the bowls. Dietary Aide G did not wash his hands upon entering the kitchen from outside, prior to stacking the cups on the tray or serving the dessert into the bowls. During an observation on 07/28/2025 at 12:01 p.m., Dietary Aide H was observed as she stood by the steam station and rubbed the back of her neck with her left hand. Dietary Aide H did not wash her hands during the observation. Dietary Aide H stood by the steam station until the Dietary Manager said it was time to begin to serve. During an observation on 07/28/2025 at 12:10 p.m., Dietary Aide H held a plate as she scooped mashed potatoes onto the eating surface. Observed Dietary Aide H's thumb touched the eating surface of the plate, and the tip of the thumb touched the mashed potatoes. Dietary Aide H did not wear gloves and had not washed her hands prior to serving. Dietary Aide H picked up another plate and touched approximately 1 1/2 inches of eating surface of the plate with her thumb and her thumb brushed against the biscuit on the plate. Observed Dietary Aide H hand to be shaky. Observed Dietary Aide H as she picked up a third plate and spooned spinach onto the plate with her thumb across the top of the plate touching the eating surface of the plate. Observed juice from the spinach touched (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary Aide H's fingers. Observed Dietary Aide H wiped her right hand on the side of her pant leg. Dietary Aide H did not wash her hands during the observation. During an interview on 07/29/2025 at 1:25 p.m., the Assistant Dietary Supervisor said she knew she was not supposed to grab the silverware by the eating end surfaces of the utensils. The Assistant Dietary Supervisor said she should not touch the end that would go into the residents' mouth. The Assistant Dietary Supervisor said she had been trained in the proper way to handle utensils and knew her action could cause cross contamination. The Assistant Dietary Supervisor said cross contamination could cause germs that could make the residents or anyone who ate from the kitchen sick. During an interview on 07/29/2025 at 1:40 p.m., [NAME] E said he knew he should have washed his hands and changed gloves in between using the oven mitts that had been used by other staff in the kitchen and in between temping food. [NAME] E said the fact that the oven mitts were not washed or sanitized between use by others could cause cross contamination. [NAME] E said the action could have a negative impact on the residents by causing cross contamination and the residents could become ill. During an interview on 07/29/2025 at 1:50 p.m., Dietary Aide H said she was trained on the need to not touch the eating surfaces of plates and said the fact that she did could cause cross contamination. Dietary Aide H said the negative outcome of her action could cause germs to get into the food, which could make the residents ill. Dietary Aide H said she knew she was not supposed to touch food with her bare hands and said she was trained on the need to wash her hand when she touched surfaces, such as wiping her hand on her jeans. Dietary Aide H said she was aware that she should have washed her hands prior to serving the food and after she touched the food, but she was nervous and forgot. During an interview on 07/29/2025 at 1:59 p.m., Dietary Aide G said he was trained that when he left the kitchen and returned, he should wash his hands every time. Dietary Aide G said when he went outside to retrieve the dessert and returned, he should have washed his hands prior to serving. Dietary Aide G said this was important for the safety of the residents because his hands could have germs on them. Dietary Aide G said the residents who ate from the kitchen could become ill from eating food with germs. During an interview on 07/30/2025 at 1:53 p.m., the Dietary Manager said the issues related to not washing hands did not meet her expectations. The Dietary Manager said the negative outcomes specifically to the staff not washing his hands when he left the kitchen to go outside were food poisoning and sickness. The Dietary Manager said [NAME] E who used gloves and did not change them or wash his hands between use of the oven mitts between tasks did not meet her expectation as he could cause cross contamination. The Dietary Manager said she would increase monitoring to avoid future occurrences to ensure the residents were not exposed to cross contamination or illness. During an interview on 07/30/2025 at 3:00 p.m., the Operations Manager said the issues related to hand washing and sanitation in the kitchen did not meet her expectations. The Operations Manager said she expected staff to abide by policy. The Operations Manager said touching the end of the silver ware could cause a negative outcome and introduce what was on the staffs' hands to the residents. The Operations Manager said the staffs' actions could cause cross contamination and cause the residents to become ill. Record review of the facility's policy, Employee Sanitary Practices, dated 2021, revealed, food and nutrition services employees will practice good personal hygiene and safe food handling procedures. 2. Wash hands before handling food using Posted hand washing procedures. 6. Use utensils to handle food, avoiding bare hand contact with food. Disposable gloves are a single use item and should be discarded after each use. Hands must be washed prior to using gloves and after removing gloves. 7. Avoid touching mouth or face while preparing food (And wash hands if contaminated.). 10. Equipment and work areas should be cleaned and sanitized after use. 11. Use these sidelines in handling clean dishware, glassware, and flatware:a. Use clean hands.b. Pick flatware and cups up by their handles.c. Pick dishes up by the rims. Record review of the facility's policy, Hand Washing, dated 2021, revealed, Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures. Hands and exposed portions of arms should be washed immediately before engaging in food preparation. 1. When to wash hands:a. When (continued on next page)		

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F 0850 Level of Harm - Potential for minimal harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility, with a capacity of more than 120 beds, failed to employ a qualified social worker on a full-time basis. The facility failed to ensure the facility had a full-time social worker between the time of 6/25/2025 to 07/30/2025. This failure could affect all residents of the facility by placing them at increased risk of psychosocial decline and poor quality of life. The findings included: Review of facility provided employee list provided on 07/28/2025 revealed no social worker on staff. During an interview on 07/30/2025 at 2:10 PM the OM stated they did not currently have a social worker. The OM stated the previous social worker's last day was on June 25, 2025. The OM stated she posted the position on June 11th but had not received applications from licensed social workers, until this past Monday, 07.29.2025. The OM stated she had raised the salary last week and added a sign on bonus. The OM stated her expectation was to have a full-time licensed social worker. The OM stated she did not feel like there was a negative effect to the residents, because staff were covering the duties of the social worker. The OM stated the facility did not have a policy for social services. The OM stated what led to the failure was the availability of licensed social workers in the area and possibly the salary. Record review of CMS Form 3740 titled Bed Classification dated 07/28/2025 revealed the facility had a licensed capacity of 123 resident beds.		