STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675668	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based interviews and record review, the facility failed to ensure each resident was free from misappropriation of resident property for 2 of 3 residents (Resident #2 and Resident #3), reviewed for drug diversion. The facility failed to prevent the misappropriation of Resident #2 and Resident #3's hydrocodone-acetaminophen 5-325 mg (formerly known under the brand name Norco, this combination medication containing 5 mg of hydrocodone [an opioid analgesic] and 325 mg of acetaminophen [also known as Tylenol] is used to treat pain). This failure could place residents at risk for not receiving their prescribed medications, unrelieved pain, and decreased quality of life. Findings include: 1.Record review of Resident #2's face sheet dated 5/8/25 indicated he was [AGE] years old, admitted to the facility on [DATE] with diagnoses including, Herpes viral vesicular dermatitis (a painful skin infection caused by the Herpes Simplex Virus); myelopathy (neurological deficits and pain stemming from damage or injury to the spinal cord, often resulting from compression or other forms of injury); peripheral vascular disease (a circulatory condition where blood vessels outside the heart and brain narrow, block, or spasm, restricting blood flow which can cause pain) and unspecified pain. Record review of the MDS dated [DATE] indicated Resident #2 usually made himself understood. The MDS indicated Resident #2 had mildly impaired cognitive ability (BIMS of 9). The MDS indicated Resident #2 required extensive assistance with bed mobility, transfers, and toilet use. Record review of the care plan dated 3/31/25 indicated Resident #2 had chronic pain. The care plan interventions included administer prescribed medications as ordered by the physician. Record review of the active physician order with a start date of 3/21/25 detailed Resident #2 was to be administered hydrocodone-acetaminophen 5-325 mg 1 tablet every four hours as needed for moderate to severe pain. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/8/25 at 1:55 p.m., Resident #2 sat in his wheelchair in his room. Resident #2 said his pain had been well managed since she had been at the facility and no complaints. Resident #2 said the pain medication the facility administered him for pain was effective. Resident #2 said he was not in any pain at the time of the interview and observation. 2.Record review of the face sheet for Resident #3 dated 5/8/25, indicated she was [AGE] years old, admitted to the facility on [DATE] with diagnoses including cirrhosis of the liver (chronic liver disease where scar tissue replaces healthy liver tissue, impairing the liver's ability to function normally, an often painful condition), muscle spasm, chronic pain, and polyneuropathy (a painful condition where damage or dysfunction affects multiple peripheral nerves throughout the body). Record review of the MDS dated [DATE], indicated Resident #3 made herself understood and understood others. The MDs indicated she had intact cognitive function (BIMS of 15). The MDS indicated Resident #3 required extensive assistance with showering, dressing the lower body, and personal hygiene. The MDS indicated Resident #3 frequently experienced pain during the 5 day look back period which occasionally made it difficult for her to sleep at night, rarely or not at all interfered with rehabilitation services, and occasionally interfered with day to day activities. Record review of the care plan dated 4/4/25 indicated Resident #3 experienced chronic pain in her back and both legs. The car plan interventions included, administer prescribed medications as ordered by the physician. Record review of the active physician order with a start date of 4/7/25 detailed Resident #3 was to be administered hydrocodone-acetaminophen 5-325 mg 1 tablet every six hours as needed for pain. During an observation and interview on 5/7/25 at 1:00 p.m., Resident #3 sat smiling in her wheelchair. Resident #3 said her pain had been well managed since she had been at the facility and no complaints. Resident #3 said sometimes she would have increase in pain after therapy but added the pain medication the facility administered her for pain was effective. Resident #3 said she was not in any pain at the time of the interview and observation. Record review of the provider investigation report (PIR) dated 4/23/25 detailed that LVN A discovered on 4/15/25 at approximately 9:00 pm that Resident #2 had 29 tablets of hydrocodone/acetaminophen 5-325 mg replaced with extra strength Tylenol and Resident #3 had 7 tablets of hydrocodone/acetaminophen 5-325 mg replaced with extra strength Tylenol. The provider investigation report detailed that the narcotic sheets and pill bottles were confiscated and locked up, medication cart and medication room audits were performed by the DON and no other issues were identified. Pain assessments for all residents were completed on the hall on which Resident #2 and Resident #3 resided with no adverse findings. The pharmacy consultant was notified and also performed medication cart and medication room audits with no additional issues identified. The extra strength Tylenol was replaced with the prescribed hydrocodone/acetaminophen 5-325 mg. The provider investigation report detailed the facility identified six nurses who had access to the locked medication cart from which the pills were taken. Those nurses provided witness statements. The nurses that had access to the cart on Wednesday the 14th and Thursday the 15th were drug tested . Of those nurses LVN A tested positive. Her results were sent for additional testing as she provided evidence she (LVN A) had a prescription for the medication herself. (The additional testing was to determine if the medication in her system was outside of the prescribe range). The local police department, state agency resident physician and medical director were notified. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the signed witness statement dated 4/17/25 signed by LVN A detailed that she worked the evening shift of 4/15/25. The statement detailed that at approximately 8:30 p.m., Resident #3 asked for a pain pill and a muscle relaxer. LVN A retrieved the bottle of hydrocodone/acetaminophen Resident #3 had brought from home with her upon her admission to the facility. LVN A detailed that when she opened the bottle to dispense 1 tablet she noticed the medication did not appear to be Hydrocodone/acetaminophen but looked more like Tylenol. LVN A detailed she used pill identifier to confirm her suspicion and the pills were Tylenol. LVN A said she knew one other resident also took Hydrocodone/acetaminophen from a pill bottle that had been sent with him form another nursing facility, so she checked that resident's (Resident #2's) medication as well, and found that it too was Tylenol. An interview with LVN A was attempted on 5/5/25 at approximately 10:00 a.m. and 5/8/25 at 10:58 a.m., detailed messages were left on her voicemail each time. No return call was received. Record review of the police report date 4/16/25 detailed that the officer responded to call at the facility in reference to theft of pills. The officer reported he spoke the DON and the administrator who informed him LVN had found that hydrocodone pills were missing and had been replaced with extra strength Tylenol. The reported detailed that the DON explained both residents had admitted to the facility with the pill bottles and that the pills had been counted and returned to the bottles on their admission. The report detailed that the DON reported she could not be sure the bottles had hydrocodone in the bottles when the residents arrived to the facility. The report detailed the Administrator wished to file charges in the manner . An interview with the police officer that took the police report was attempted on 5/8/25 at 2:20 p.m. the dispatcher took the investigators information and indicated she would have the officer return the call, no return call was received. During an interview on 5/8/25 at 2:00 p.m., the DON said the facility tested nurses with access to the carts for the 48 hours prior to discovery of the event as neither resident reported increased or unrelieved pain so it was thought the switch had happened recently. In addition, when all the findings were presented to the corporate office the instruction they (the DON and Administrator) received was to test nurses for the past 48 hours with access to the cart. The DON said LVN A tested positive but reported she had a prescription for the medication. The DON said the decision was made to send the sample to an outside lab to perform additional testing to see if the levels in her sample indicated levels above the prescribed amount. However, the results from that lab were inconclusive. The DON explained apparently in the transport of the sample to the lab the requisition slip was separated from the specimen so the lab refused to run the test. The DON said LVN A had been suspended pending the investigation and was phoned and told the results were inconclusive and she would be allowed to return to work. The DON said however, LVN A no called no showed and has not returned. The DON said LVN A not returning to work was suspicious but they could not substantiate she had swapped the pills. The DON said we really could not say when the swap occurred. The DON said going forward they will not accept pills bottles/administer controlled substances from pill bottles. The DON said in the event the pills are provided to the facility they will be sent to the pharmacy for verification and placed in blister packs (a blister pack is a type of packaging where a product [often a pill] is encased in a plastic bubble attached to a card. The primary purpose of a blister pack is to protect the product, offer a clear display for consumers, and sometimes provide tamper-evident features). The DON said if a controlled medication for pain is needed while this process takes place the medications will be administered from the facilities emergency kit. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 2:50 p.m., the Administrator said misappropriation had occurred and while he suspected LVN A he did not know for certain. The Administrator said the facility performed and in-services and going forward no pill bottles would be accepted. He said if a resident came from home or another facility with the pain pills in bottles the pills would be sent to the pharmacy for verification and the pills would be placed in blister packs. Review of the facility policy and procedure titled Abuse, Neglect and Exploitation, revised October of 2023, stated The facility will provide protection for the health welfare and rights of each resident .prohibit and prevent the .misappropriation of resident property. Review of the facility policy and procedure titled Controlled Substances, dated 6/1/22, stated 9. Upon receipt the nurse receiving the medication and the individual delivering the medication verify the name, dose, and quantity of each controlled substance being delivered . The policy and procedure did not address receiving pills in bottles and those pills being verified by pharmacy consultant and placed in blister packs.

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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** 41093 Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical record maintained for each resident were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for resident records. The facility failed to ensure accurate documentation was documented for Resident #1's wound care on 3/21/25 when the DON (who did not perform the wound care) edited LVN B's (the nurse that performed the wound care) progress note for Resident #1 five days after the wound care (3/26/25). This failure could place residents at risk for delayed interventions, appropriate interventions, health complications and decreased quality of life. Findings include: Record review of Resident #1's face sheet dated 5/8/25 indicated Resident #1 was [AGE] years old, admitted to the facility on [DATE] with diagnoses including non-pressure chronic ulcer of buttock with fat layer exposed, unspecified skin changes, and history of cellulitis (a common bacterial infection of the skin and underlying tissues). Record review of the MDS dated [DATE] indicated Resident #1 made herself understood and usually understood others. The MDS indicated Resident #1 had moderate cognitive impairment (BIMS of 12). The MDS indicated Resident #1 was dependent on staff for toileting, showering, and lower body dressing. The MDS also indicated Resident #1 required substantial assistance for dressing the upper body and personal hygiene. The MDS indicated she had a surgical wound. Record review of the care plan revised on 4/15/25 indicated Resident #1 had an open area to the left hip and was a surgical sight. The care plan interventions included treat area per physician order, cleanse area to left hip with normal saline, pat dry, apply calcium alginate and cover with a dry dressing. During an interview and observation on 5/5/25 at 12:08 p.m., Resident #1 said she received her wound care daily and had no complaints with the care she received. Resident #1 said she had already received wound care for the day. Resident #1 said she had not missed any days of wound care to her knowledge. Record review of the nursing note dated 3/21/25 written by LVN B stated changed dressing to left hip. Previous dressing was dated 3/18/25. Tolerated well. The note was edited by the DON on 3/26/25 and read Changed dressing to left hip. Tolerated well. During an interview on 5/5/25 at 1:00 p.m., LVN B said her note read the previous dressing was dated 3/18/25 because that was the date on the dressing when she went to perform the daily dressing change on 3/21/25. LVN B said she did not know why the DON had changed her note. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 2:00 p.m., the DON said she edited the note because it was a red flag and suggested Resident #1 had not received daily wound care. The DON said she had not performed the wound care herself. The DON said she suspected LVN B had falsified the note to cause trouble. The DON said she should not have changed the note but should have talked to LVN B and documented her concerns but should not have changed the note. The DON said she should have handled it differently. During an interview on 5/8/25 the Administrator said he expected resident records to be complete and accurate. Record review of the facility policy and procedure, revised April 2012 title Guidelines for charting and Documentation stated .the purpose of charting and documentation is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care .a legal record that protects the resident the care providers and the facility .General rules .2. Be concise, accurate and complete .