STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676026	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Will-O-Bell	412 N Dalton Bartlett, TX 76511

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 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** 42949 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for two (Resident #1 and Resident #2) of four residents reviewed for medications. The facility failed to ensure Resident #1 was discharged home without two of Resident #2's medications (Trazadone and Tegretol). This deficiency put residents at risk of consuming unprescribed medications, harm, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including chronic myelomonocytic leukemia (cancer of the blood-forming cells of the bone marrow), acute pulmonary edema (buildup of fluid in the lungs), and hypertension (high blood pressure). Review of Resident #1's quarterly MDS assessment, dated 01/24/24, reflected a BIMS of 9, indicating a moderate cognitive impairment. Section N (Medications) reflected he was taking an antidepressant. Review of Resident #1's quarterly care plan, dated 01/25/24, reflected he had impaired immunity related to cancer with an intervention of monitoring/documenting/reporting PRN any s/sx of infection. Review of Resident #1's physician orders, on 04/23/24, reflected he did not have an order for Tegretol or Trazodone. Review of Resident #1's Discharge Summary, dated 03/07/24 and completed by RN B, reflected his admission diagnoses, disposition (where he went), condition on discharge, discharge diagnoses, and prognosis. No medications were documented. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676026	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Will-O-Bell	412 N Dalton Bartlett, TX 76511

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, insomnia (trouble sleeping), stroke, vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrients to a part of the brain), and unspecified convulsions. Review of Resident #2's quarterly MDS assessment, dated 04/15/24, reflected a BIMS of 7, indicate a moderate cognitive impairment. Section N (Medications) reflected he was taking an antidepressant. Review of Resident #2's quarterly care plan, dated 02/08/24, reflected he used antidepressant medication related to depression and insomnia and had a seizure disorder related to a stroke with interventions of giving medications as ordered. Review of Resident #2's physician order, dated 11/04/21, reflected Tegretol 200 MG - give 1 tablet by mouth two times a day related to unspecified convulsions. Review of Resident #2's physician order, dated 09/13/23, reflected Trazodone HCl Oral Tablet - give 75 mg by mouth at bedtime related to major depressive disorder. During a telephone interview on 04/23/24 at 10:58 AM, Resident #1's FM A stated he was discharged home on 03/07/24 in the late afternoon. She stated when they were leaving, RN B handed her a plastic bag of his medication. She stated once she got home, she realized she knew nothing about the medications or when he was supposed to be administered them, so she went back to the facility. She stated RN B wrote either AM or PM on the blister packs and verbally told her what the medications were. She stated she did not write anything down for her. She stated while going through the medications at home, FR C noticed that Resident #2's name was on two of the medications. She stated she was appalled she had been given someone else's medication and was happy she had not given any to Resident #1. She stated she immediately called the facility and RN B came and picked up the two blister packs. Observation of pictures provided by FM A, on 04/23/24 at 11:15 AM, revealed two blister packs of medication, Trazadone and Tegretol, with Resident #2's name on the top. During an interview on 04/23/24 at 11:34 AM, the DON stated her expectation of nurses upon a resident discharge was they reviewed their medications with them and their RP. She stated the nurses should hand-write all medications and when they were to be administered. She stated the resident and/or RP and the nurse should sign the medication list and a copy should be given to the resident and/or RP. The DON was asked if she was aware of the incident that occurred on 03/07/24 with Resident #1 regarding medications. She stated she had not. Once informed she stated she was extremely shocked and stated she would have expected RN B to have notified her immediately. She stated a resident receiving/administering medication that was not prescribed to them could lead to some very serious outcomes. She stated she was going to start in-servicing nursing staff right away. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676026	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Will-O-Bell	412 N Dalton Bartlett, TX 76511

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/24 at 11:48 AM, RN B stated she remember it being a very chaotic evening on 03/07/24. She stated she remembered going over with Resident #1's FM A the medications, doses, and times, but must have missed verifying the name on the medications. She stated not long after they left the facility, FM A came back and wanted her to explain the medications for her, in which she did. She stated she provided her with a list of the medications. She stated about 30 minutes later, FM A called and told her there were two medications that did not belong to Resident #1 mixed in with his medications. She stated she could not believe it, but when she got to Resident #1's home, there were two medication cards that belonged to Resident #2. She stated she should have notified the DON but she just forgot. She stated she felt awful because someone could take the wrong medications, somebody could go without their prescribed medications, or someone could have been hurt. During an interview on 04/23/24 at 1:29 PM, the NP stated she expected nurses to reconcile medications with their orders before sending them home with residents. She stated it was only common sense to verify what was on their MAR versus what was in your hand. She stated negative outcomes of receiving/taking the wrong mediation could be altered mental status, passing out, falling, sedation, or death. Review of the facility's in-service, dated 04/23/24 and conducted by the DON, reflected nursing staff were in-serviced on the facility's policy for discharge mediations. Review of the facility's Discharge Medications Policy, revised March of 2022, reflected the following: Unless otherwise specified by facility policy, or contrary to current law or regulation, medications shall be sent with the resident upon discharge. Controlled substances may not be released to the resident upon discharge. . 5. The nurse shall review medication instructions with the resident, family member or representative before the resident leaves the facility. 6. The nurse shall complete the medication disposition record, including: a. the resident's name .