STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676090	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Court Health Center	2617 Antilley Road Abilene, TX 79606

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure completion of a discharge summary including a recapitulation of the resident's stay, and final status at discharge for 2 of 5 (Resident #6 and Resident #29) residents reviewed for discharge summary. The facility failed to complete a discharge summary for Resident #6 and Resident #29. This failure could place residents at risk of not having complete records after permanent discharge from the facility and disruption in the continuity of care. Findings included:Resident #6Record review of Resident #6's face sheet dated 07/09/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 03/20/2025 with the following diagnoses Pneumonia (infection that inflames the lungs), hypertension (high blood pressure), and Dementia (general term for loss of memory). Record review of Resident #6's admission MDS assessment dated [DATE] revealed Section C Cognitive Patterns revealed Resident #6 had a BIMS score of 13, meaning cognitively intact; Section Q Participation in Assessment and Goal Setting revealed Resident #6's overall goal was to be discharged to the community. Record review of Resident #6's progress notes revealed: Dated 03/20/2025 at 11:22 AM discharged back to assisted living with all belonging. Record review of Resident #6's EMR on 07/08/2025 revealed no evidence that Resident #6 had a completed discharge summary. Resident #29Record review of Resident #29's face sheet dated 07/09/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 04/15/2025 with the following diagnoses cerebral infraction(stroke), hypertension (high blood pressure), and kidney disease. Record review of Resident #29's admission MDS assessment dated [DATE] revealed Section C Cognitive Patterns revealed Resident #29 had a BIMS score of 15, meaning cognitively intact; Section Q Participation in Assessment and Goal Setting revealed Resident #29's overall goal was to be discharged to the community. Record review of Resident #29's Discharge MDS assessment dated [DATE] revealed Section A Identification Information revealed that Resident #29 discharged to the community on 04/15/2025. Record review of Resident #29's progress notes revealed: Date 04/15/2025 at 5:35 PM Resident discharged at 5:35 pm to home. Resident accompanied by her [family member]. Record review of Resident #29's EMR on 07/09/2025 revealed no evidence that Resident #29 had a completed discharge summary.During an interview on 7/08/2025 at 2:30 PM the MDS coordinator stated the nurse who discharged the resident was responsible for completing a discharge summary. The MDS Coordinator stated the discharge summary should have been in the resident's EMR. During an interview on 7/09/25 at 9:48 AM The DON stated her expectation was that every resident who had been discharged should have had a discharge summary in their EMR. The DON stated the discharge summary should have been completed by the nurse that discharged the resident. The DON stated the discharge summary was supposed to be completed in the resident's progress notes. The DON stated she was not able to locate a discharge summary for Resident #6 and Resident #29. The DON stated she was responsible to monitor, and that discharges were discussed in morning meeting. The DON stated what led to failure was staff did not complete the discharge summary. Record review of facility policy titled, Discharge Summary and Plan dated 11/28/2017 revealed; When a resident's discharge is anticipated, a discharge summary. will be developed to assist the resident to adjust to his/her new living environment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care for 1 of 16 (Resident #82) residents reviewed for care plan completion. The facility failed to include Resident #82's colostomy and diagnosis of Diabetes Meletus in the baseline care plan within the required 48-hour timeframe. This failure could place residents who were newly admitted at risk for not receiving necessary care and services or having important care needs identified.Findings included:Record review of Resident #82's electronic face sheet dated 07/08/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #82's diagnosis included Type 2 Diabetes Mellitus with Hyperglycemia (metabolic disease characterized by elevated blood sugars) and Colostomy status (colon diverted to an artificial opening in the abdominal wall).Record review of Resident #82's admission MDS assessment dated [DATE] revealed Section C Cognitive patterns revealed Resident #82 had a BIMS score 14 meaning cognitively intact. Section H Bladder and Bowel-Ostomy. Bowel continence-Always incontinent. Active Diagnosis-Diabetes Mellitus. Section Q Participation in Assessment Goal Setting revealed Resident #82's overall goal was to be discharged to the community.Record review of Resident #82's Physician's Orders revealed a start date of 07/01/2025, Inspect ostomy site skin for breakdown, signs of infection or excoriation of skin. Change ostomy appliance every 3 days.Record review of Resident #82's baseline care plan dated 07/01/2025 revealed no evidence of colostomy care or diabetes mellitus. During an observation and interview on 07/07/2025 at 11:00 AM revealed Resident #82 was sitting up in wheelchair in her room. Resident #82 was observed to have a colostomy to lower abdomen. Resident #82 stated she was not sure how long she had the colostomy. Resident #82 stated the staff took care of her colostomy. During an interview on 07/09/2025 at 09:05 AM the DON stated she monitored care plans by having daily clinical meetings and weekly quality of care meetings with the IDT. The DON stated baseline care plans were initiated by the charge nurse that admitted the resident. The DON stated the baseline care plan should have addressed the resident's diagnoses and any special needs or support. The DON stated she did not know why a baseline care plan had not addressed the colostomy or diagnosis of Diabetes Mellitus. The DON stated the effect of not having items on care plan was that staff would not have needed information to provide care. During an interview on 07/09/2025 at 09:15 AM the MDS Coordinator stated the charge nurse that admitted the resident was responsible for completing the baseline care plan upon admission. The MDS Coordinator stated the effect on residents could have been the resident's skin or stoma would not be monitored, and that could have caused complications for the resident. The MDS Coordinator stated the baseline care plan should have included the diagnosis, skin assessment and any medical devices. The MDS Coordinator stated she did not know how this failure occurred. The MDS Coordinator stated the IDT met each morning for clinical meetings where care plans were reviewed. Record review of facility's policy titled Care Plans-Baseline dated March 2022 revealed: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following:a. Initial goals based on admission orders and discussion with the resident/representativeb. Physician orders.c. Dietary ordersd. Therapy orderse. Social services andf. PASARR recommendations if applicableThe baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan (no later than 21 days after admission) The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan in developed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure that each resident received food that is palatable, attractive, and at a safe and appetizing temperature for 1 of 1 lunch meal tested for nutritive value, flavor, and appearance:The facility failed to provide palatable food served at an appetizing temperature and appetizing texture to residents on 07/07/2025.This failure could affect the residents by placing them at risk of poor food intake and/or dissatisfaction of the meals served.The findings included: During an observation and interview on 07/07/2025 at 11:01 AM revealed Resident #18 was sitting up in her recliner in her room. Resident #18 stated she had one complaint about the facility, the food. Resident #18 stated the kitchen over cooked the meat. Resident #18 stated the food was dry and tough on numerous occasions. During an observation and interview on 07/07/25 at 12:45 PM the DM joined to taste the food and take the temperature of the food on the test tray. The chicken breast was thin and dry, the temperature was 111 degrees Fahrenheit. The pork loin was tough and had a temperature of 104. The DM stated the chicken was dry and the pork was tough. The DM stated that the meats were not hot and were not at an appetizing temperature. The DM stated his expectation was that food should have been served to residents at a warm and appealing temperature. The DM stated he was responsible to ensure food was cooked and served to residents that was not overcooked and at a palatable temperature. The DM stated what led to failure of food not being warm was the facility was currently using plastic plates due to a new dishwasher being installed. The DM did not have a reason for the meat being over cooked. During an interview on 07/09/25 at 9:59 AM the ADMN stated his expectation was that food be cooked correctly, not be overcooked and served at an appetizing temperature. The ADMN stated the DM was responsible to ensure food was cooked properly and served at an appetizing temperature to residents. The ADMN stated the DM and himself were responsible to monitor staff and food to make sure food was cooked properly and served at an appetizing temperature. The AMDN stated he had made rounds during meal service and ate test trays in the dining room. The ADMN stated residents could have been affected by not wanting to eat food which could have resulted in weight loss. The ADMN stated improper training of staff and lack of oversight by the DM led to failure of food being overcooked and not at appetizing temperature. Record review of the facility policy titled, Food and Nutrition Services, dated October 2017, revealed Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and its served at a safe and appetizing temperature.

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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 observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure that staff utilized proper personal hygiene practices while handling food. These failures could place residents that eat out of the kitchen at risk for food borne illnesses.Findings included: Observation in the dining room, on 07/07/2025 between 12:00 PM and 12:45 PM revealed: DA-A entered the dining room to assist with plating the food and donned gloves(put gloves on) without washing her hands. She assisted with placing food on plates and serving to the residents. She went down the hall to the main kitchen with her gloves on, then returned to the dining room with the same gloves still on, did not perform hand hygiene, and continued to serve plates to residents. DA-A went down the hall to the main kitchen a total of 3 times and never washed her hands or changed her gloves. The DM entered the dining room and began assisting with the meal service and did not wash his hands. The DM placed a plate in the microwave, went and spoke to residents, placing his hand on one's shoulder, then returned and removed the plate from the microwave without washing his hands. The DM continued to assist with plating and serving food and never washed his hand and failed to change gloves.During an interview on 07/07/25 at 12:45 PM, the DM stated his expectation was for the staff to wash their hands constantly. The staff should wash their hands before handling any food and after touching anything other than food. He stated not using proper hand hygiene could cause infections. He stated he did not realize he had not washed his hands because he was just trying to help ensure the meal service went successfully. He stated he and his staff had been trained regarding hand hygiene and infection control. During an interview on 07/07/25 at 12:50 PM, DA-A stated she had been trained on hand hygiene and that she should have changed gloves and washed hands in between going down the hall and back. She stated she just got in a rush and got nervous because she was being watched. During an interview on 07/07/2025 at 1:00 PM, the Administrator stated hands must be washed prior to handling food and anytime that the hands were contaminated. He stated that was the DM's responsibility to ensure that the procedures were being followed. He stated not using proper hand hygiene would lead to cross contamination and infection. The Administrator verified that all residents ate from the kitchen and could be affected. The Administrator stated that he conducted observations of the dietary staff periodically. Review of facility policy titled, Preventing Foodborne Illness, revised November 2022, revealed: Policy Statement: Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy Interpretation and Implementation: 1. All employees who handle, prepare, or serve food are trained in the practices of safe food handling and preventing foodborne illness.6. Employees must wash their hands:.d. Before coming in contact with any food surfaces.g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing task.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 1 (Resident #12) of 14 residents reviewed for hospice services. The facility failed to maintain the required hospice forms and documentation, that included certificate of terminal illness and hospice election form, to ensure that the needs of the resident were addressed and met 24 hours per day to ensure Resident #12 received adequate end-of-life care.This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: Review of Resident #12's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: dementia, kidney disease, and high blood pressure.Review of Resident #12's admission MDS assessment dated [DATE], revealed a BIMS score of 13 which indicated no cognitive impairment. Review of Section O: revealed Resident #12 was on hospice care.Review of Resident #12's Comprehensive Care Plan initiated 04/11/2025, revealed: Focus: Resident is at the end stage of life and is utilizing Hospice.Review of Resident #12's electronic Physician's Orders revealed: Admit to Skilled Nursing Facility Medicare stay under the services of hospice, dated 04/10/2025.Review of Resident #12's clinical records revealed no evidence of the required hospice forms and documentation, that included certificate of terminal illness and the hospice election form.During an interview on 07/08/25 at 03:14 PM, the DON stated the =resident's certification of terminal illness, and the hospice election form should be in the hospice binder, located at the nurses' station, and available in the facility at all times. She stated she was not sure why it was not in the hospice binder. She stated the social worker was usually the person who was responsible for communication with hospice and ensuring that the required documents were in the facility. The DON stated the facility just recently hired a new social worker which was probably why the failure occurred.Review of the facility's policy titled, Hospice Program, revised July 2017, revealed in part: Policy Statement: Hospice services are available to residents at the end of life. Policy Interpretation and Implementation . 12. Our facility is responsible for: .d. Obtaining the following information from the hospice . 2.) Hospice election form 3.) Physician certification of the terminal illness specific to each resident.