STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676211	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Woods Health & Rehabilitation	1700 Woodgate Drive Waco, TX 76712

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 - Some	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** 45070 Based on interview, and record review, the facility failed to ensure 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 3 of 5 residents (Resident #1, Resident #2, and Resident #3) reviewed for medication administration, in that: LVN A failed to document the medications administered to Resident #1, Resident #2, and Resident #3, in the MAR. This deficient practice could place residents at-risk of Medication Administration Errors that leads to the danger of overdosing drugs. The findings included: Record review of Resident #1's face sheet, dated 05/25/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease, , Hypertension, Dysphagia (difficult to swallow), Encounter for palliative care, Psychotic disorder with delusions due to known physiological condition, Insomnia, Anxiety Disorder and constipation. Record review of Resident #1's MDS assessment, dated 05/20/24, revealed Resident #1 did not have a BIMS completed due to the resident rarely/ never understood. Record review of Resident #1's careplan dated 05/ 20/24 revealed: Resident/family has elected Hospice Care. Resident is at risk of complications related to dying process and the relevant intervention was: Observe for non-verbal S/S of pain to include but not limited to restlessness, agitation, facial grimacing, assess for cause and relieve as possible, provide ordered pain medications and notify MD, Hospice if not effective. Record review of Resident #1's Hospice Physician's Orders, revealed: Lorazepam Oral Tablet 0.5 MG (Lorazepam): (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give 1 tablet by mouth every 2 hours as needed for agitation x2 doses and if still agitated call hospice. Start Date-05/12/2024 and D/C Date-05/14/2024. Lorazepam Oral Tablet 0.5 MG (Lorazepam): Give 1 tablet by mouth every 2 hours as needed for anxiety for 90 Days. Start Date- 05/01/2024 and D/C Date- 05/19/2024. Record review of Resident #1's May 2024, MAR with Controlled Drug Log, revealed, Lorazepam 0.5MG administered on 05/01 at 10:30PM, 05/10 at 11:00PM, 5/11/24 at 10:00PM, 05/16/24 at 10:00PM, 05/17/24 at 6:00AM and 8:00PM, 5/18/24 at 7:50AM and 1:00PM and 05/19/24 at 9:00PM were recorded in the controlled drug log and not in the MAR. Record review of Resident #2's face sheet, dated 05/25/24, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Hemiplegia and Hemiparesis (severe loss of strength) , Aphasia (Loss of ability to understand or express speech) following nontraumatic subarachnoid hemorrhage (Bleeding in the tissue layer that cover the brain) , Dysphasia (Difficult to swallow) following nontraumatic subarachnoid hemorrhage, Hypertension, Hyperlipidemia (Excess fat in blood), Anemia in chronic kidney disease, Muscle weakness, Lack of coordination, Cognitive communication deficit, Difficulty in walking, Unsteadiness on feet and Chronic kidney disease. Record review of Resident #2's MDS assessment, dated 04/07/24, revealed Resident #2's BIMS score was 13 indicating Resident #2's cognition was intact. Record review of the careplan dated 05/ 20/24 revealed Resident #2 is at risk for pain and relevant intervention was providing scheduled pain medication (Tramadol) as ordered. Record review of Resident #2's physician's orders, reviewed on 05/25/24, revealed: Ultram Oral Tablet 50 MG (Tramadol HCl) : Give 1 tablet by mouth every 8 hours as needed for pain. Record review of Resident #2's May 2024 MAR with Controlled Drug Logs, revealed, Ultram Oral tablet 50MG administered on 05/22/24 at 4:40PM was recorded in the controlled drug log and not in the MAR. Record review of Resident #3's face sheet, dated 05/25/24, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Type 2 diabetes mellitus, sleep Disorder, Hypertension, Unsteadiness on feet, Muscle wasting and Atrophy, Muscle weakness, Cognitive communication deficit, Insomnia, Lack of coordination, Restlessness and Agitation, Mood Disorder, Dementia, Psychotic disturbance, Pressure ulcer of left heel, stage 2. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's MDS assessment, dated 04/30/24, revealed a BIMS score was 03 indicating Resident #3's cognition was severely impaired. Record review of the careplan dated 05/ 20/24 revealed resident #3 had demonstrated physical and verbal behaviors and the relevant intervention was giving medication as prescribed for agitation. Record review of Resident #3's physician's orders revealed: Ativan Oral Tablet 1 MG (Lorazepam): Give 1 tablet by mouth every 6 hours as needed for anxiety/agitation for 14 Days. -Start Date- 05/01/2024. Ativan Oral Tablet 1 MG (Lorazepam): Give 1 tablet by mouth every 6 hours as needed for Anxiety/agitation for 14 Days. -Start Date- 05/17/2024 Record review of Resident #3's May ,2024 MAR with Controlled Drug Logs, revealed, Ativan Oral Tablet 1 MG administered on 05/14/24 at 12:40PM, 05/15/24 at 07:25AM, 5/17/24 at 2:00AM and 5:00PM and 05/21/24 at 2:55PM were recorded in the controlled drug log and not in the MAR. During an interview on 05/25/24 at 3:00pm with the DON she stated, any medication that was administered to a resident should be entered in the MAR as soon as possible. If it was a scheduled medication and if it was not administered, the rationale for not administering should be given instead of keeping it blank. If it was a PRN medication, the dose and the time of the administration should be entered in the MAR. DON stated this was the expectation from the nurses as it was the minimum requirement of the nursing competency. DON stated, she identified the nurse who made these documentation errors and its was LVN A who works in the night shift. DON stated she was in the facility relatively new and had not done any auditing to identify any medication documentation errors. During an interview on 05/25/24 at 3:10PM with ADM, she stated as per facility policy and procedure documentation of the medication administration on MAR was mandatory. She stated entering administration documentation in the MAR was important to minimize the risk of drug overdose as MAR was a communication tool as well among the nursing staff, informing the latest medication administration status. On 05/25/24 at 12:30PM and 3:15pm LVN A was not available for an interview over the phone. Record review of in-service records revealed there were no in services on documentation of administration of medication, between 01/01/24 and 05/25/24. Record review of facility's undated policy Medication Administration and general guidelines reflected: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's MAR is initiated by the person administering a medication, in the space provided under the date and on the line for that specific medication dose administration or if utilizing an Electronic Medical Record, the initials of the nurse electronically stamped into the record. All licensed personnel/ nurses will be assigned a secure password which will not be shared or given out to other personnel. When PRN medications administered, the following documentation is provided: Date and time of administration, dose, route of administration (if other than oral), and if applicable the injection site Signature or initials of person recording administration and signature or initials of person recording effects if different from person administering. Record review of the Texas Board Of Nursing website https://www.bon.texas.gov/rr_current/217-11.asp.html#:~:text=RULE%20%C2%A7217.11,Nurses%20with%20advanced%20practice%20authorization. accessed on 05/31/24 reflected: The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses, and Registered Nurses with advanced practice authorization. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted. (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall . . (D) Accurately and completely report and document: (i) the client's status including signs and symptoms. (ii) nursing care rendered. (iii) physician, dentist or podiatrist orders. (iv) administration of medications and treatments.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

45070

Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food storage and labeling in that:

The facility failed to ensure food and beverages were safely stored, labeled, and dated in the walk in refrigerator and freezer on 05/25/24.

This deficient practice could place residents at risk of foodborne illness.

The findings included:

Observation of the walk in Refrigerator on 5/25/24 at 10:30AM revealed:

1. One plastic container containing pink substance has no name or opened/prepared and used by dates on it. The DA B accompanied the investigator and stated it was slices of ham.

2. One plastic container with chopped mix vegetables has no name or opened/prepared and used by dates on it.

3. One steel tray containing 6 pieces of sandwich without any name and opened/prepared and used by dates on it. The DA B accompanied the investigator and stated she was not sure when it was prepared.

4. One cardboard box containing 6 packets of ham without any name and opened/prepared and used by dates on it. The DA B stated they were ham removed from the freezer for thawing and was not sure when it was removed from freezer.

5. One transparent plastic container containing yellow substance without any name and with a sticker with 05/15/24 written on it. The DA B accompanied the investigator and stated it was peach prepared on 05/15/24.

6. One plastic tray containing two packets of creamy yellow substance without any name or opened/prepared and used by dates on it. The DA B accompanied the investigator and stated it was beaten egg removed from the freezer and was not sure how long it was stored in the refrigerator.

7. One transparent plastic container containing a white substance without any name and with a sticker with 05/17/24 written on it. The DA B accompanied the investigator and stated it was coleslaw prepared on 05/17/24.

8. One steel tray containing about 2 dozen of brown palm size pieces without any name and with a sticker with 05/18/25 written on it. The DA B accompanied the investigator and stated it was baked chicken prepared on 05/18/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. One cardboard box of parmesan cheese with a sticker with 05/11/24 written on it. 10. There were two boxes and a pile of 3 boxes of food items stored on the floor. Observation of the walk-in freezer on 05/25/24 at 10:50AM revealed there were two piles of cardboard boxes of food items stored on the floor. During an interview on 05/25/24 at 11:00AM, DA B stated she started working at the facility a few weeks ago and learning the facility policies and procedures . She stated as it was Saturday the DM was off from duty. She stated she was not sure about the policy of the facility about the storage of prepared or opened food items. She stated she believed the items past 3 days should be thrown away. A few seconds later she stated might be 5 days. She said she did not get any training at the facility related to food handling. During an interview on 05/25/24 at 11:05AM DA C stated she was new at the facility. She stated she was not sure about the life of prepared food items. DA C stated all the items should be stored with labels indicating the expiry dates on it. She said she did not get any training at the facility for food handling. During an interview on 05/25/24 at 11:15AM ADM stated the DM was off from work in the weekends and was not reachable for a telephone interview. She stated the expectation was the staff follow the policy and protocol of the facility for food handling. Record review of the in-service records revealed there were no in services in between 01/01/2024 and 05/25/24 on preparing, labelling, and storing of food items. Review of the facility's undated policy Storage of Food in Refrigeration reflected: . 4. All containers must be labeled with the contents and date food item was placed in storage. 5.Previously cooked foods can be held in refrigeration of 41 degrees or lower for up to 7 days and then must be discarded. 6.Food items that remain sealed from the supplier may be held until the expiration date if unopened