

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2025
NAME OF PROVIDER OR SUPPLIER  Wesley Woods Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700</b></p> <p>Based on interview and record review the facility failed to ensure the resident had the right to be informed of, and participate in, his or her treatment including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care and treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred for one of nine residents (Resident #1) reviewed for resident rights .</p> <p>The facility failed to notify Resident #1's responsible party when his labs result on 2/25/2025 indicated his lithium levels were out of range.</p> <p>This failure could place residents at risk of a lack of a dignified existence, self-determination and quality of life.</p> <p>Findings include:</p> <p>Record review of Resident # 1's face sheet, dated 3/28/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Traumatic Subarachnoid Hemorrhage (Brain bleed), Type 2 Diabetes (a blood sugar regulation disorder), bipolar disorder (mood disorder), Depression, Hypertension (high blood pressure), Kidney Disorder, and history of Stroke (brain attack). The face sheet further reflected that a family member was Resident #1's responsible party.</p> <p>Record review of Resident #1's admission MDS assessment, dated 2/25/2025, reflected a BIMS of 10, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #1's orders reflected a lab order, dated 2/21/2025, for a Lithium level.</p> <p>Record review of Resident #1's lab results, dated 2/25/2025, reflected a lithium level of 1.4 H [high] with a reference range of 0.6 to 1.2</p> <p>Record review of Resident #1's progress notes, dated 2/26/202, reflected the following: Labs received and reviewed by nursing, copy of labs placed in folder for MD review.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/2025 at 3:13 pm, Nurse A stated she was the charge nurse on the unit on 2/25/2025 when Resident #1's lab results had come back. She stated she did not know the results had come back or had been placed in the folder. She said usually one of the ADONs would print out the lab results and bring them directly to the charge nurse and then the charge nurse would call the RP. She stated if they were put right in the folder, she would not be aware the lab results were back, and the RP needed to be called. She stated for Resident #1's lithium level result, if she had known, she would have called the NP or MD first, then called the family or RP. She stated she did not call Resident #1's RP and that's why there was no progress note about this in the EMR. She stated by not calling Resident #1's RP, the RP could lose trust in the nursing staff and not feel comfortable with resident's being at the facility .</p> <p>During an interview on 3/28/2025 at 1:08 PM, the ADON B stated it was the charge nurses on the unit's responsibility to call the RP or family members about out-of-range lab results. She stated she had received the lithium level results for Resident #1 and reviewed them and put them in the practitioner folder at the nurse's station but the charge nurse on the unit should have called Resident #1's RP . She stated it was not unusual to leave lab results in the folder for the practitioner to review, that was the facility's normal practice. She stated she was unaware the other ADON was printing out the results and handing them to the charge nurses on the unit. She stated she had concerns because there was no documentation that the charge nurse had called Resident #1's RP in the EMR. If the RP was not notified, there could be allegations that the facility wasn't taking care of their family member and there would be no progress notes for continuity of care. She stated, we probably should have taken extra time for the lithium levels and called the RP, then added we probably should have done a little bit better .</p> <p>During an interview on 3/28/2025 at 1:50 PM, the DON stated the out-of-range lab results for Resident #1 should have been communicated to the RP by the charge nurse. The DON stated her concerns would have been that Resident #1 had only been in the facility a week and the RP would not have known what was going on with the resident's care and the resident had rights to have this information. She stated one of the ADON's would print out lab results for the nurses and take them to the unit. She stated they recently made a change and split the units between two ADONs and the ADON for the unit Resident #1 was on may not have been aware the results needed to be printed out and taken to the charge nurse .</p> <p>During an interview on 3/28/2025 at 5:00 PM, the AD stated her expectation was the out-of-range lithium results be communicated to the RP by the charge nurse on the unit. She stated the RP had a right not know what was going on with the residents.</p> <p>During an interview on 3/28/2025 at 1:34 PM, the MD stated his expectation was that he would receive a phone call for any lab results that were a critical level, but out of range level results could just go in the folder at the nurse's station for him or the NP to review. He stated Resident #1 was clinically he was doing pretty fine and was not aware of any clinical concerns. When asked if the RP should have been called for the out of range lithium level, the MD stated probably so noting Resident #1 had only been in the facility a week at that point and there should have been notification to the POA or RP - whoever is the decision maker - that he had some abnormal lab values.</p> <p>Record review of the facility's, undated, Policy Resident Rights reflected the following:</p> <p>The resident has the right:</p> <p>(continued on next page)</p>		

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