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	04/08/2025

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 - Immediate jeopardy to resident health or safety 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** 44700 Based on interview and record review, the facility failed to maintain accurate and timely medication records to minimize the potential for medication related adverse consequences or events for three (Resident #1, Resident #2 and Resident #3) of five residents reviewed for med errors. A medication error occurred on 11/28/2024 where residents # 1, #2 and #3 all received a double dose of their scheduled narcotic pain medication. Residents #1, #2 and #3 received their first dose at 7pm and the second dose at 8:30 pm. The nursing facility failed to: o follow their policy for medication administration to avoid errors. o document and monitor Residents #1, #2, and #3 after the medication errors to ensure no adverse effects o notify the Responsible Parties of Residents #1, #2, and #3 after medication errors An Immediate Jeopardy (IJ) was identified on 04/4/2025 at 5:50 pm and the facility was notified and given an IJ template. A revised template was provided on 4/7/2025 at 2:05 pm. While the IJ was removed on 04/8/2025 at 3:55 pm, the facility remained at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. The deficient practice could place residents at risk of medication overdoses leading to loss of consciousness, loss of breathing function and death. Findings include: Resident #1 (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident # 1's face sheet dated 4/4/2025 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: Dementia (memory disorder), history of brain cancer, benign neoplasm of ascending colon (tumor in the colon), major depressive disorder, bipolar disorder, anxiety disorder, contractures of bilateral(both) lower legs, left hip pain, and chronic pain (other). Resident #1's face sheet indicated a FM was her RP. Resident #1's quarterly MDS dated [DATE] indicated she had a BIMS of 12 suggesting mild cognitive impairment. Review of Resident #1's orders on 4/4/2025 reflected a physician's order dated 8/11/2024 as follows: Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen), Give 1 tablet by mouth four times a day for pain. Review of Resident #1's narcotic count sheet for Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) indicated it was administered on 11/28/2024 at 7 am, 11 am, 3pm, 7pm and 8:30 pm Resident #2 Review of Resident #2's face sheet dated 4/4/2025 reflected an [AGE] year-old female admitted on [DATE] with diagnoses that included: Dementia (memory disorder), seizures, low back pain, delusional disorders, osteoarthritis of bilateral knees (chronic joint disease resulting in breakdown of cartilage). Resident #2's face sheet indicated a FM was her RP. Resident #2's quarterly MDS dated [DATE] indicated she had a BIMS of 11 suggesting mild cognitive impairment. Review of Resident #2's orders on 4/4/2025 reflected a physician's order dated 10/16/2024 as follows: Percocet Oral Tablet 5-325MG (Oxycodone w/Acetaminophen), Give 1 tablet by mouth four times a day for pain. Review of Resident #2's narcotic count sheet for Percocet Oral Tablet 5-325MG (Oxycodone w/Acetaminophen) indicated it was administered on 11/28/2024 at 7 am, 11 am, 3pm, 7pm and 8:30 pm. Resident #3 Review of Resident #3's face sheet dated 4/4/2025 reflected an [AGE] year-old female admitted on [DATE] with diagnoses that included: Dementia (memory disorder), chronic kidney disease, chronic pain, hypertension (high blood pressure) and cognitive communication deficit. Resident #3's face sheet indicated a FM was her RP. Resident #3's quarterly MDS dated [DATE] indicated she had a BIMS of 12 suggesting mild cognitive impairment. Review of Resident #3's orders on 4/4/2025 reflected a physician order dated 8/11/24 as follows: HYDROcodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen), Give 1 tablet by mouth four times a day for pain. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's narcotic count sheet for HYDROcodone-Acetaminophen Oral Tablet 10-325 MG indicated it was administered on 11/28/2024 at 5 am, 11 am, 3pm, 7pm and 8:30 pm. Record Review of a facility medication error form dated 11/29/2024 revealed a med error had occurred on 11/28/2024 that included resident #1, resident #2, and resident #3 and involving MA-A and LVN B and that the Physicians' statement or orders: continue to monitor, no changes and action taken was education on med rights, write up. During an interview on 4/4/2025 at 12:45 pm, the DON stated on 11/28/24 there was a medication error involving resident #1, resident #2 and resident #3 where they received a double dose of their narcotic pain medication. She stated that occurred because MA -A had not signed off the medications in the EMR and LVN B saw they were due on the EMR and gave them again. She did one on one in-services with the staff involved in the med error but not the rest of the nursing staff. She stated she probably should have included all nursing staff on the in-service training for medication errors. She stated the facility did fill out a med error form, but there were no progress notes indicating the RPs had been notified or that the residents had been monitored for adverse effects after the med error. During an interview on 4/4/2025 at 2:20 pm the Administrator stated there was no follow up monitoring done for resident' #1, resident #2, and resident #3, the med errors were not documented in the EMR progress notes, the RPs were not notified and the med errors were not noted on the 24-hour report to pass information to the next shifts. During an interview on 4/4/2025 at 3:16 pm the facility Medical Director stated he had concerns because there was no follow up monitoring done on the residents with the narcotic med errors. He stated he would have expected staff to monitor for altered mental status, clinical sedation, and respiratory depression. He stated at a minimum vital signs should have been checked to include monitoring oxygen saturation and respirations as an overdose of narcotic could cause a resident to stop breathing. During an interview on 4/5/2025, MA-A stated she had given scheduled narcotic pain meds on 11/28/2024 to resident #1, resident #2, and resident #3 and had signed them off on the narcotic count sheet. She stated she did not sign them off in the EMR, because she was just helping the nurse out before she left at the end of her shift and did not have time. MA-A stated it was her responsibility to sign off the medications in the EMR because she was the one that had actually given the medications to the residents. She stated she had been trained on medication administration and the person that gave the medication is the one responsible for signing off the EMR and the narcotic count sheets. She stated she had written the medication administration on a piece of paper and had given it to the LVN B before she left. She stated she found out later LVN B had forgotten about her note and had also given resident #1, resident #2, and resident #3 the same medications and as a result the residents got a double dose of narcotics. She stated a double dose of narcotics could cause residents to become sleepy, their blood pressure could drop, they could fall, stop breathing and lose consciousness, or even die. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/7/2025 at 1:19 pm, LVN B stated she worked the night shift on 11/28/2024 and gave resident #1, resident #2, and resident #3 their evening dose of narcotic medication because it was showing due in the EMR. She stated she also signed the medications out on the narcotic count sheet. She stated she had forgotten that MA-A told her the medications had already been given but not signed off in the EMR and had not noticed the previous administration on the narcotic count sheet. She stated she had been trained on medication administration and the person that gave the medication is the one responsible for signing off the EMR and the narcotic count sheets. She stated residents that got a double dose of narcotic medications could stop breathing, they could have a cardiac arrest, they could die depending on what else they have going on [a resident] could die pretty fast. Review of the undated facility policy on Medication errors and Drug Reactions revealed: 1) All medication errors and drug reactions must be promptly reported to the Director of Nursing Services, attending physician and the pharmacist. 2. A detailed account of the incident must be recorded and should include documentation of: a. Time and date of the incident b. Name, strength, and dosage of medication administered c. Resident's reaction to the medication d. Condition of the resident e. Any treatment administered; and f. Date and time the physician was notified, and instructions given. 3. Monitor closely any resident who has received incorrect medication or is having a drug reaction. Immediately report to the Director of Nursing Services and attending physician any change in the resident's condition. The ADM was notified on 04/4/2025 at 5:50 pm that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 04/07/2025 at 4:54 pm: On 4/4/25 an abbreviated survey was initiated at [Facility name]. On 04/04/25, the surveyor provided an Immediate Jeopardy Template notification. that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety. Complaint Survey regarding Medication Errors. Failure is as follows: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Residents #1, 2, and 3 o on 11/28/24 a medication error occurred and there was not documentation by facility staff of a medication error in the progress notes. Responsible parties for Residents # 1, 2, and 3 were contacted and made aware of the med errors on 4/4/2025. The Medical Director was made aware of past med error. o All residents have the potential to be affected by deficient practices of medication administration. o Missed Medication Report was pulled for the past 6 months to ensure no other residents were administered narcotics twice. o Review of all Narcotic sheets for the past 6 months was reviewed to ensure that there were no double doses of narcotics based on the sign out sheets and comparing to nurse notes and EMARs. o To prevent from occurring, the ADONs are reviewing count sheets daily to ensure no double doses have been administered. Training Topic: Administering Medications, Medication Errors, and Notification to Physicians, Family, and others. The Chief Operating Officer and Director of Clinical Operations educated the DON and Administrator with a posttest to show understanding The Director of Nurses Provided training to the nurses and medication aides on duty Training started on 4/4/25 at 2:50pm for nurses and med aides on duty with a post test to show understanding Training was concluded at 6:15 for all staff on-site Training will be concluded for those not present, they will be educated and required (continued on next page)

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 04/08/2025

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	to pass a post test before they take their next assignment New Hire's will receive training from the DON or designee during new hire orientation The facility does not utilize agency staff Notification Chief Operating Officer was notified at 2:31 on 4/4/25 Director of Clinical Operations was notified at 2:31 on 4/4/25 Medical Director was notified by the administrator on 4/4/25 at 2:43 pm. Immediate Action The person who made the error(s) received an in-service and a disciplinary action. Residents with med errors on 11/28/24 were assessed on 4/4/25 and 4/5/25 and all notifications were made and documented on 4/4/25 and 4/5/25 by the ADON and CHARGE NURSE AD-HOC QA meeting Ad-Hoc QAPI meeting was held on 4/4/25 at 3:30PM -attendance was Medical Director via email and phone contact - COO via email and phone contact - ADON in person - DON in person - Administrator in person preparing the meeting Recurrence Prevention Missed Medications report will be ran during daily stand-up meeting to review medications that were missed. Any medication errors, the staff member will be contacted and an in-service and disciplinary action (where necessary) will be (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	initiated. All nursing staff who administer medications will be given reminder. education over the policy and procedures by the DON or Nurse Managers that will be initiated immediately following the med error until all staff who administer medications has received re-education. The ADONs are reviewing count sheets to ensure no one has been doable dosed or that a dose has been missed and not documented in the EMAR. This is part of their morning routines. Monitoring for effectiveness Missed Medication Report will be ran prior to daily stand-up meeting by the DON This will be an ongoing process. The Surveyor monitored the POR on 4/8/2025 as followed: During interviews on 4/8/2025 from 12:22 pm - 3:45 pm with two LVNs, two MAs, DON and AD all stated they had been in-serviced on medication errors, policies on administering medications, appropriate notifications, post med error monitoring and completing a post test on all topics. Observations of two different medication administrations with a nurse and a MA on 4/8/2025 between 12:22 pm - 12:51 pm revealed no medication errors. Review of an Ad Hoc QAPI Agenda, dated 4/4/2025, reflected the Medical Director, Administrator, Chief Operating Officer, ADON, Business Office Manager, Maintenance Director, Housekeeping Director, Director of Nursing, Human Resource Coordinator, Social Worker, and the Admission/Marketing Coordinator were in attendance where they discussed medication errors and failure to document; In-services over administering medications, medication errors, and notifications and reviewed post test for administering medications. Review of an in service dated 4/4/2025 conducted by the Chief Operating Officer reflected the Administrator and Director of Nursing were in services on administering medications, medication errors and drug reactions, notifications to family, and posttest on medication administrations. Review of an in service dated 4/1/2025 conducted by the Director of Clinical Services reflected the DON and both ADONs were in serviced on the following: compliance concern, training and medication errors. Review of an in service dated 4/4 - 4/5/2025 conducted by the Director of Nursing reflected all staff from all shifts were in serviced on the following topics: med error policy, administering medication policy, notification to family, MD & others and the post test. Review of missed medication audit report dated 4/6/25 - 4/8/25 reflected no missed meds and no new med errors. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	While the IJ was removed on 04/8/2025 at 3:55 pm, the facility remained at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.