

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  05/06/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700</b></p> <p>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 three (Resident #1 and Resident #3) of five residents reviewed for pharmaceutical services.</p> <p>On 5/2/2025, two (2) medication cards - one from Resident #1 and one from Resident #3 - were observed with white tape on the reverse side of the card. The tape on the reverse side of the medication card indicated the potential for tampering. Administrative and nursing staff failed to be aware of patch use, failed to verify that the patches used were from the pharmacy, and failed to be trained on the use of patches to include when patches were acceptable for use in the facility policies and procedures.</p> <p>On 4/30/2025 during shift overlap, LVN-A and LVN-B discovered a narcotic count sheet reconciliation error. LVN-A noted on the count sheet the medication had been wasted, when it had not been wasted.</p> <p>The deficient practice could place residents at risk of medication overdoses or medication errors leading to adverse reactions, loss of consciousness, loss of breathing function and death.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Review of Resident #1's face sheet dated 5/2/2205 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).</p> <p>Review of Resident #1's significant change MDS dated [DATE] indicated she had a BIMS score of 8 suggesting moderate cognitive impairment.</p> <p>Review of Resident #1's current care plan revealed she was at risk for pain related to her history of back injuries/surgeries, history of a left knee replacement, and arthritis of the knees with interventions that included provide medications as ordered.</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
-----------------------------------------------------------------------	-------	-----------

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  05/06/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #1's progress notes dated 4/30/2025 revealed no note about the medication error and no note that resident had been assessed.</p> <p>Review of Resident #1's progress notes for 5/1/2025 at 6:30 am reflected VS 97.7,78,18,118/68, 96% RA 0 -10 PAIN alert and oriented x 2 per normal base line. confused per normal baseline. resident is able to voice needs and has no s/s of distress noted. Residents awake and alert sitting in bed with HOB elevated. PO fluids encouraged and provided.</p> <p>Review of Resident #1's orders dated 10/16/2024 reflected a physician order as follows: Endocet Oral Tablet 5-325MG (Oxycodone w/Acetaminophen), Give 1 tablet by mouth every 4 hours for chronic pain.</p> <p>Further review of Resident #1's orders revealed an order as follows: HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth one time only for pain until 04/30/2025.</p> <p>Review of Resident #1's pain assessment on the MAR on 4/30/2025 reflected a pain level of 4.</p> <p>Review of Resident #1's narcotic count sheet for Endocet Oral Tablet 5-325MG (Oxycodone w/Acetaminophen) revealed an entry on 4/30/2025 at 7:40 pm with a count of 36 tablets that had a line drawn threw it and initialed by LVN-A and another entry on 4/30/2025 at 9:40 pm stating correct count 37 signed by LVN-A.</p> <p>Resident #2</p> <p>Review of Resident # 2's face sheet dated 5/3/2025, reflected she was a [AGE] year-old female admitted on [DATE] with diagnoses that include: Dementia (memory disorder), history of brain cancer, benign neoplasm of ascending color (tumor in the colon), major depressive disorder, bipolar disorder, anxiety disorder, contractures of bilateral lower legs, left hip pain, and chronic pain (other).</p> <p>Review of Resident #2's quarterly MDS dated [DATE] indicated she had a BIMS score of 12 suggesting mild cognitive impairment. Resident #2's face sheet indicated a FM was her RP.</p> <p>Review of Resident #2's current care plan revealed she has a diagnosis of chronic pain with interventions that included provide PRN medications as indicated.</p> <p>Review of Resident #2's orders reflected a physician 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.</p> <p>Review of Resident 2's narcotic count sheet for Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) indicated it was administered on 4/30/2025 as follows: one table given at 4:00 pm, one tablet given at 7:36 pm and one tablet wasted at 9:30 pm. The line with the wasted comment was signed by LVN-A and DON.</p> <p>Resident #3</p> <p>(continued on next page)</p>		

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  05/06/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of face sheet dated 5/6/2025 reflected Resident #3 was an [AGE] year-old female admitted on [DATE] with diagnoses that include: Alzheimer's Disease (a progressive disease that destroys memory), Dementia (memory disorder), chronic pain, hypertension (high blood pressure) heart disease and cognitive communication deficit.</p> <p>Review of Resident #3's significant change MDS dated [DATE] indicated she had a BIMS score of 10 suggesting moderate cognitive impairment.</p> <p>Review of Resident #3's orders reflected an order dated 5/11/2024 as follows: Ultram Oral Tablet 50 MG (Tramadol HCl), Take 1 tablet by mouth every 8 hours as needed.</p> <p>During an observation on 5/2/2025 at 12:10 pm a blister card of Oxycodone medication for Resident #1 was noted to have two pieces of white tape on the back of the card. Further review of the blister card and pharmacy label revealed no labeling to indicate the blister pack had been modified by the pharmacy. The blister card observed did not have any deficits on the front side of the card where the tape had been observed on the reverse side.</p> <p>During an observation on 5/2/2025 at 1:11 pm a blister card of Tramadol medication for Resident #3 was noted to have two pieces of white tape on the back of the card. Further review of the blister card and pharmacy label revealed no labeling to indicate the blister pack had been modified by the pharmacy. The blister card observed did not have any deficits on the front side of the card where the tape had been observed on the reverse side.</p> <p>During an interview on 5/2/2025 at 12:32 pm, LVN-C stated she had not noticed the tape on the back of the cards when she counted the cart this morning. She stated if she was checking in medications from the pharmacy and saw that tape on the back, she would not accept it and would tell the DON in case there was tampering. She stated she had never received any training that covered getting medications cards from the pharmacy with tape on the back was allowed.</p> <p>During an interview on 5/2/2025 at 12:35 pm, MA-D stated she had never seen any medication cards with tape on the back and that she was very anal about checking the back of the cards. She stated if she did see a card with tape on the back, she would tell the DON if she saw they were tampered with. She stated they have plain white labels for use on the plastic med card dividers and the tape looked very similar so she would suspect tampering. She stated she had never received any training about accepting medication cards from the pharmacy with tape on the back.</p> <p>During an interview on 5/2/2025 at 1:01 pm, LVN-E stated she did sign for medications from the pharmacy and they were not supposed to accept the cards if that were tampered with. She stated if she saw the tape on the back, she would not accept the medications and she would tell the DON. She also stated if she saw card with tape on the back while she was counting with another nurse, she would not accept the keys to the cart and would tell the DON. She stated she had never had training about medication cards with tape on the back and what to do.</p> <p>During an interview on 5/2/2025 at 1:10 pm, MA-F stated she had not noticed the tape on the back of the card this morning and she had never seen it before. She stated if she had, she would report to the DON and would not accept the keys to the cart. She stated she had never had training about medication cards with tape on the back and what to do.</p> <p>(continued on next page)</p>		

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  05/06/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 5/2/2025 at 1:36 pm, the ADM stated she had a conversation with the pharmacy rep and they informed her they will put tape consistent with what was observed on the back of the medication cards if there is a pharmacy error made. She stated she was unsure if the facility policy allowed them to accept cards like that from the pharmacy. She stated probably not but she would pull the policy.</p> <p>During an interview on 5/2/2025 at 4:10 pm, the DON stated they had received a letter from the pharmacy today regarding tape on the back of medication cards but was not aware of a policy in place prior to today that allowed pharmacy to send cards with tape on the back and for staff to accept med cards with tape on the back. She stated to her knowledge there had never been in services with the staff on acceptable use of patches for medication cards from the pharmacy. She stated the tape on the back could appear as if the cards had been tampered with.</p> <p>During an interview on 5/2/2025 at 5:06 pm, the Pharmacy Director stated I don't know that anything exists in writing for the nursing facility to use patches. He stated there was nothing between the parties and they had come up with new ways of doing corrections so there were no problems in the future. He stated going forward they will have stickers that can be used for corrections that can be printed.</p> <p>Record review of pharmacy letter received 5/2/2025 from the Pharmacy Director stated Any blister cards containing medications with blister errors (i.e. incorrect number of pills in a bubble, etc.) may be corrected by the pharmacy staff so long as the correct patch is placed over the appropriate bubble(s). All instances will be verified by a [pharmacy name] pharmacist to assure accuracy prior to being send out. Appropriate patches to be used can be ordered from [supplier] and include, but are not limited to plain white, white with yellow and foil. Note that foil patches many only be sued for blister cards that can be heat sealed while other patches may be used for blister cards that cannot be heat sealed.</p> <p>Record review of facility policies revealed there was no policy that addressed the use of tape patches by the pharmacy to correct pharmacy errors or that medication card with patches were allowed to be accepted by nursing staff for resident use.</p> <p>Review of facility audit completed 5/2/2025 reflected an additional 13 blister cards were identified as having tape on the back of the card and had been re-ordered from the pharmacy if an additional blister card was not already available.</p> <p>Review of the undated facility policy on Receiving Medications from the Pharmacy states:</p> <p>It is the policy of this facility to assure all medications are correctly delivered and errors rectified as soon as possible to assure proper handling of all medications and to assure a system is adhered to at all times.</p> <p>#8 - Any discrepancies found in the acceptance of the medications should be IMMEDIATELY notified to the technician making the delivery.</p> <p>Review of the undated facility policy on Shift Change and Medication Cart Responsibility states:</p> <p>(continued on next page)</p>		

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  05/06/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>It is the policy of this facility to ensure the transition from one shift to the next is appropriate, ensure proper handling of all medications and minimize risk.</p> <p>#7 - Any discrepancies found in the acceptance of the medications should be IMMEDIATELY notified to the charge nurse and Director of Nurses and Administrator.</p> <p>During an interview on 5/3/2025 at 12:05 pm, LVN-A stated she had worked on 4/30/2025 and discovered a narcotic count discrepancy at shift change when she was counting narcotics with the oncoming nurse for evening shift, LVN B. She realized the count was off and called the DON. The DON told LVN-A to mark on Resident #2's narcotic count sheet that one tablet was wasted to make the count correct. She stated she had called the NP and received an order for a one-time dose of hydrocodone. She stated on her drive home, she realized she should not have falsified the information on the narcotic count sheet and marked wasted on Resident #2's sheet because it had not been wasted. She stated she had a lapse in judgement at the moment because she has been a nurse [AGE] years and this had never happened before, and it scared her.</p> <p>She stated she had received training on narcotic count sheets, and they were supposed to notify the DON when there was a discrepancy. She stated falsifying narcotic count sheets could lead to med errors and could cause potential harm to residents like a bad reaction, an overdose, they could end up in the hospital, or over sedated that could lead to respiratory depression.</p> <p>During an interview on 5/3/2025 at 2:08 pm, LVN-B stated she had come in to work night shift on 4/30/2025 and was counting narcotics with LVN-A the nurse going off shift. She stated they discovered the count was off for Resident #2's Hydrocodone. She stated LVN-A noted in writing by the count discrepancy wasted and initialed it but LVN-B did not initial it.</p> <p>During an interview on 5/3/2025 at 1:06 pm, the DON stated she was aware of the narcotic count discrepancy that occurred on 4/30/2025 by LVN-A. The DON stated she told LVN-A to mark the narcotic count sheet that the medication had been wasted and she knew it had not been wasted but had actually been given to Resident #1. She stated LVN-A and herself both signed the correction. She stated she realized it was wrong and I really don't have an explanation for why I told her to do that. DON was asked if the direction to mark that the medication has been wasted on the narcotic count sheet she had given LVN-B was the appropriate decision and she stated, absolutely not - it was not the right decision.</p> <p>During an interview on 5/3/2025 at 1:54 pm, the NP stated a facility nurse had called her on 4/30/2025 about a one-time order for Resident #2 to have hydrocodone. She stated she was not aware of any documentation falsification on the narcotic count sheet and said, I would not let anyone falsify documents She stated she did not normally have problems with this facility and the staff were fairly consistent and they don't have a lot of agency staff. She stated her concerns with false narcotic count sheet documentation would be patient safety as it could lead to a bad patient outcome.</p> <p>During an interview on 5/3/2025 at 1:25 pm, the ADM stated she was not aware of the falsification of the narcotic count sheet documentation. She stated her expectation was that staff would fill out the narc sheet correctly to show it was given or not given. She stated LVN-A should not have marked the narcotic count sheet as wasted if the medication had not been wasted.</p>		