STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675593	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WISTERIA PLACE	**3202 S WILLIS ST ABILENE, TX 79605**

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** - Few	**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** 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 one of one resident (Resident #23) observed to have medications left at the bedside. Registered Nurse A placed Resident #23's medications at the bedside and left the room. This failure could place residents at risk for missed medications, medication being taken at the wrong time and the potential for other residents to have access to medications not prescribed to them. Findings: Resident #23 Record review of Resident #23 face sheet dated September 3, 2020 reveal that she was a [AGE] year-old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record Review of Resident #23 medication sheet revealed the following medications ordered: [MEDICATION NAME] Capsule 100mg 1 capsule by mouth 2 times daily ([MEDICAL CONDITION] pain) Bepreve Solution 1 drop in both eyes 2 times daily (allergies [REDACTED].) [MEDICATION NAME] HCL 50 mg tablet one tablet by mouth 3 times daily (pain) Tylenol Extra Strength one tablet by mouth 3 times daily (chronic pain related to right scapula) Aspirin 81 mg one tablet by mouth daily ([MEDICAL CONDITION]) [MEDICATION NAME] tablet 10 mg one by mouth daily (depression) [MEDICATION NAME] Tablet 20mg one tablet by mouth at bedtime ([MEDICAL CONDITION] reflux disease) Junuvia tablet 100 mg one tablet by mouth daily (diabetes mellitus) [MEDICATION NAME] 40mg tablet one tablet by mouth daily ([MEDICAL CONDITION]) [MEDICATION NAME] Solution 23 units at bedtime (diabetes mellitus) Multiple Vitamins-Minerals one tablet daily (supplement) Metropolol [MEDICATION NAME] Tablet 37.5mg one tablet by mouth 2 times daily (episodic [MEDICAL CONDITION] episodes) [MEDICATION NAME] Tablet 50mcg one tablet by mouth daily ([MEDICAL CONDITION]) Observation on 09/02/2020 at 10:10am RN A brought in medications for Resident #23. RN A had a medicine cup of pills and a medication cup of liquid. The surveyor told the resident she would return to continue their conversation. Observation on 09/02/2020 at 10:13 am the surveyor returned to Resident #23 room, both medication cups were sitting on the bedside stand. RN A was not in the room. It was unknown what meds were in these medication cups. The medication preparation had not been witnessed by the surveyor. RN A was observed at the medication cart in the hallway preparing medications for another resident. RN A returned to the room to administer medications to the resident in the other bed. Observation on 09/02/2020 10:17am RN A entered the room to observe Resident #23 take her medications. Interview 09/02/2020 at 10:25am with RN A stated she did not leave the room, she only turned around and thought another staff was going to enter the room. She said that they don't leave medications at the bedside. She said she thought the other nurse was in there. She said that they are not supposed to just leave the pills at the bedside. Interview 9/3/20 1:15 PM Resident #23 said They leave my morning medications out for me to take pretty often, it's usually when I'm in the bathroom. I'm taking too many and some of them I just won't take, so I put them back in the cup and set it out and they come pick it up later. Only thing that bothers me, is that I'm taking too many. But they shouldn't do that. Interview 09/02/2020 at 10:35am with the ADON revealed the policy of the facility is not to leave medications at the bedside. She has never witnessed medications left at the bedside before. I'm disappointed that the nurse didn't know better. Interview 09/02/2020 at 10:45am with the DON revealed her expectations are for her nurses to follow the facility policy and procedure in administering medications and that the medications are not to be left at the bedside. Expectations are for the staff to identify the resident and to check the medications against the medication administration record. It is never acceptable to leave medications at the bedside and leave the room. Record Review of facility Policy/Procedure-Nursing Clinical section Care And Treatment Revised 05/2007 states: It is the policy of this facility to ensure that the six rights of medication administration are followed in order to ensure safety and accuracy of administration. Procedures: The six rights of medication administration are as follows to ensure safety and accuracy of administration . . Ensure that the resident has taken her medications prior to leaving the room. The medications cannot be left in the resident's room unattended.
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.** Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchen. The facility failed to ensure food items in the freezer and refrigerator were dated, labeled and sealed appropriately to prevent contamination. They failed to store dry paper goods up off the floor and away from moisture to prevent contamination. This failure could affect residents by placing them at risk for food borne illness and food contamination. The findings include: In an observation of the Kitchen on 09/01/20 at 9:40 AM, numerous items were observed that included: Observation of Cold Storage Refrigerator on 09/01/20 at 9:45AM revealed: 1 Half a pan of Iced Cake covered with no label of use by date. 2 2 glasses of orange juice on second shelf with no covers or labels on them. 3. Pitcher of Apple Juice on second shelf with no label on plastic cover and partially uncovered. 4. 1 Container of strawberries on top shelf with green and white fuzzy debris covering them. Observation of Cold Storage Freezer on 09/01/20 at 10:10AM revealed: 1. Approximately half a bag of cinnamon rolls with no label of open/use by date. 2. Approximately 1/4 of a bag of dinner rolls with no open/use by date. 3. Package of Tator Tots with no label for received/use by date. 4. Package of Chicken Tenders with no label for received/use by date. 5. Package of Hush Puppies with no label for received/use by date. 6. Numerous boxes of frozen foods with no labels of received date on them. Observation of Dry Storage of Paper goods on 09/01/20 at 10:20AM revealed: 1. Wetness of concrete floor halfway into the room. 2. Boxes of Styrofoam hinged food trays laying on side directly on ground on the wet concrete. In an interview with the Food Service Director on 09/01/20 at 10:30AM, she said that there should be a label when something is received from the truck and a use by date when something is opened. She said that, if an item comes in on the truck and they already have another one, the oldest is pushed forward and the newest is stored at the back of the shelf behind that item. She said that when something is placed in the refrigerator it should be covered and have a label on it that states what it contains and a use by date. She said that all items, food and food storage containers should never be directly on the floor and should be on some type of shelving that keeps them off the floor. Record Review of Food Storage/Food Label Policy, No date, provided by facility was a printed copy of Federal Regulation F812. It stated When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated .Food and food products should always be kept off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents to maintain food quality and prevent

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) contamination . .Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date In an interview with LNFA on 9/2/20 at 8:15AM, he said that the facility policy for food storage and labeling is directly connected to the tag in that, the regulation at F812 is their policy.