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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wells Nursing Home Inc	201 W Madison Avenue Johnstown, NY 12095

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, record review, and interviews during a survey, the facility failed to ensure residents were free from abuse for one (1) (Resident #1) of three (3) residents reviewed for abuse. On 02/04/2026, Resident #1 became combative during a shower, striking Certified Nurse Aide #2. Certified Nurse Aides #1 and #2 continued to provide shower care. Certified Nurse Aide #1 stated they continued the care and tried to deflect some of the blows toward Certified Nurse Aide #2. Resident #1 sustained injuries including skin tears, scattered bruising to right arm, hematoma (a localized collection of clotted or partially clotted blood outside blood vessels, often resulting from injury or trauma) on the back of head, a head laceration (cut), and a bruised left ankle. This resulted in actual harm of Resident #1 that is not Immediate Jeopardy and is past non-compliance. This is evidenced by:Resident #1 was admitted with the diagnoses of unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), chronic diastolic (congestive) heart failure (when the left lower chamber of the heart becomes stiff, leading to decreased blood flow and other complications) and chronic kidney disease (state of progressive loss of kidney function and the ability to remove waste from the body). The Minimum Data Set (an assessment tool) dated 01/02/2026 documented the resident was able to be understood, was able to understand others, and had intact cognition. The policy and procedure titled Abuse Prevention Manual, last revised 01/01/2026, documented it was their policy that residents environment would be free from verbal, mental, and physical abuse, mistreatment, neglect, misappropriation of resident's property, and exploitation. The policy and procedure titled Comprehensive Care Planning, effective 01/01/2026, documented a person-centered comprehensive care plan would be developed for each resident and includes the right to receive goods and services outlined in the plan of care and also the right to refuse treatment.The Comprehensive Care Plan titled Resident #1 is resistive to care and refuses showers was initiated on 12/10/2025 and included the interventions: If approaches are unsuccessful when combative and agitated, leave safe and reapproach.The Facility Investigation documented that on 02/04/2026 at 11:30 AM it was reported to Director of Nursing #1 that Resident #1 had been injured in the shower while combative with care. An investigation was completed, and a violation of the comprehensive care plan was found. Two (2) certified nurse aides (#1 and #2) were terminated as a result of this incident. The Progress Note dated 02/04/2026 at 12:38 PM written by Registered Nurse #1 documented Resident #1 was reported to be combative with care, at baseline, and Certified Nurse Aides #1 and #2 continued with the shower, resulting in injuries to the resident including:^Skin tear on left elbow measured one (1) centimeter by one (1) centimeter.^Skin tear left forearm measured six and a half (6.5) centimeters by four (4) centimeters with surrounding bruising measured at eight (8) centimeters by four (4) centimeters.^Scattered bruising to right arm.^Skin tear on right elbow one and a half (1.5) centimeters and able to be approximated with steri strips^Hematoma back of head measured two (2) centimeters by two (2) centimeters.^Laceration back of head below hematoma measured one (1) inch by one (1) inch.^Bruising to left ankle measured three (3) centimeters by three (3) centimeters. During an interview on 02/17/2026 at 11:51 AM, Registered Nurse #1 stated they were informed of the incident after it happened. The resident was already in their room when (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Registered Nurse #1 arrived. They assessed the resident's injuries and applied treatments as per the facility protocol for skin tears. The Medical Director was informed. They stated the two (2) certified nurse aides (#1 and #2) that were in the shower room with the resident were immediately removed from the floor and sent to Director of Nursing #1. They stated the resident, at baseline, was resistant to personal care such as showering and basic activities of daily living and the two (2) certified nurse aides were regulars on the unit and were familiar with the resident and their behaviors. They stated they do not know why Certified Nurse Aides #1 and #2 continued to shower the resident when the resident was being combative, but they should have stopped the shower and returned the resident to their room safely. They stated the resident was alert and oriented at baseline but had short-term memory issues that could affect recall of specific incidents.During an interview on 02/17/2026 at 12:24 PM, Director of Nursing #1 stated they became aware of the incident within 20 minutes of it occurring, and they removed Certified Nurse Aides #1 and #2 from the unit and immediately suspended them. Certified Nurse Aides #1 and #2 were terminated after the investigation showed a care plan violation with subsequent injury to the resident. They stated upon initiating the investigation they also started education for all staff, clinical and non-clinical, on customer service, abuse and abuse reporting, and the resident's right to refuse care. Certified Nurse Aides #1 and #2 had no prior incidents of care plan violations or abusive behaviors. They stated the certified nurse aides were well familiar with the resident and their behaviors. During an interview on 02/17/2026 at 3:30 PM, Certified Nurse Aide #3 stated they were familiar with the resident and had heard about the incident but had no direct knowledge of it. They stated the incident occurred on the day shift, while they work the evening shift. They stated that the resident had long standing behaviors and needed a gentle approach to get anything done with them. They stated the resident had a history of refusing showers for weeks at a time, allowing only the basic bed bath sometimes. They stated they received education that residents had the right to refuse care, even with dementia, and it was important for the residents that their choices be respected. They also stated they received education on abuse and reporting anything that seemed out of the ordinary, and how to interact with residents in a pleasant, friendly manner even if the residents were not being friendly. During an interview on 02/18/2026 at 10:36 AM, Certified Nurse Aide #1 stated they were not familiar with Resident #1's care, they had been asked by Certified Nurse Aide #2 to assist with a shower because the resident could become combative. They stated the resident was initially hesitant to take a shower, but when Resident #1 was informed their family member wanted the shower, Resident #1 reportedly stated I don't want to, but I'll do it. They stated the resident became combative after the shower started and the resident was striking Certified Nurse Aide #2. Certified Nurse Aide #1 stated they helped keep the resident from sliding off the shower chair and tried to deflect some of the blows toward Certified Nurse Aide #2. They stated they noticed the large skin tear on Resident #1's left arm and after the resident was dressed and, in their room, Certified Nurse Aide #2 reported it to the nurse.During an interview on 02/19/2026 at 12:44 PM, Medical Director #1 stated they were no longer the medical director for the facility. They stated they did assess Resident #1 after the incident on the same day and found minor injuries, no significant injuries. They stated they ordered radiography on head, arms, hips, and ankle with no significant findings. They stated the resident was unable to say how they struck their head resulting in the hematoma, but Medical Director #1 surmised it could have happened in the shower chair while the resident was resisting care. They stated they were not involved in the follow- up to the incident as they did not work at the facility any longer. During a telephone interview on 03/03/2026 at 10:30 AM, Family Member #1 stated that resistance to care was the resident's baseline. They stated it was one of the reasons the resident was placed in long term care because the resistance to care in the community setting led to the resident being unkempt and unable to take care of themselves. They stated they made the facility aware they would be visiting the resident the day the incident occurred. They visited the resident and found the resident bleeding and reported it to Director of Nursing #1 immediately and returned to the room where Registered Nurse #1 was wrapping the resident's arm (continued on next page)

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	335314	A. Building B. Wing	03/03/2026

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