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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455637	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1802 S 31st Temple, TX 76504

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to immediately notify the resident's physician when there was a significant change in the resident's physical status for one (Resident #1) of four residents reviewed for resident rights, in that: The facility failed to ensure Resident #1's NP was notified until the 5th day of her experiencing constipation. This failure placed residents at risk of illness, uncontrolled pain, and a decreased quality of life. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including irritable bowel syndrome, chronic pain, morbid obesity, and panic disorder. Review of Resident #1's quarterly MDS assessment, dated 04/22/24, reflected a BIMS score of 15, indicating no cognitive impairment. Section H (Bowel and Bladder) reflected she was always incontinent of her bowels. Review of Resident #1's quarterly care plan, dated 04/11/24, reflected she had bowel/bladder incontinence r/t impaired mobility with an intervention of changing as soiled. Review of Resident #1's bowel movement tracking sheet, from 04/09/24 - 05/08/24, reflected she did not have a bowel movement from 04/21/24 until 04/25/24. Review of Resident #1's progress notes, dated 04/25/24 at 5:00 AM and documented by LVN A, reflected the following: [Resident #1] verbalized not having BM for couple of days. Previous shift offered her some stool softeners and MiraLAX, so we continue to monitor and will advance treatment as per HCP orders when need arises. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER: Wellington Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 1802 S 31st Temple, TX 76504	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's progress notes, dated 04/25/24 at 6:50 AM and documented by LVN B, reflected the following: . [Resident #1] stated that she had not had a BM in 6 days and had received PRN medications enema, stool softener, lactulose, and prune juice. None were effective. Sent to ER per resident request. Review of Resident #1's progress notes, dated 04/25/24 at 6:45 PM and documented by LVN B, reflected the following: Called (hospital) to check on [Resident #1]. Nurse informed this nurse that [Resident #1] was admitted with SIRS. 2 enemas given in ED and medications were effective . Review of Resident #1's hospital records, dated 04/25/24, reflected she was diagnosed with SIRS, Cellulitis of left leg, and wheezing. The issues resolved during hospitalization were cellulitis of left lower leg, constipation, and SIRS. During an interview on 05/08/24 at 10:38 AM, Resident #1 stated she had gone many days back in April without having a bowel movement. She stated none of the medications or interventions were working so she requested to go to the hospital. During an interview on 05/08/24 at 10:49 AM, LVN B stated they had been administering Resident #1 stool softeners, laxatives, and giving her prune juice but nothing had worked. She stated she could not remember if she had notified the NP regarding her constipation prior to her requesting to go to the hospital, but she did notify her after she went to the hospital. During an interview on 05/08/24 at 11:43 AM, the NP stated she had not been notified of Resident #1's constipation prior to the day she went to the hospital. She stated it was her expectation that she be notified any time a resident had a change in condition, even if it was constipation. She stated other interventions could have been tried, such as a suppository. During a telephone interview on 05/08/24 at 12:25 PM, LVN A stated when she got report from LVN B on the evening of 04/24/24, and she was informed Resident #1 had not had a BM in a few days and she had recently given her stool softener and prune juice. She stated she spoke to Resident #1 who did not complain of pain and told her she wanted to wait until the morning to see if she had a BM before thinking about going to the hospital. She stated the next morning around 5:00 AM, Resident #1 stated she was in a lot of pain and wanted to go to the hospital. She stated she told her the NP would be at the facility soon and she agreed to wait for her. She stated she texted the NP at that time. She stated she was not sure if the NP had been aware of her constipation before that time. She stated before the NP arrived, Resident #1 voiced she wanted to go to the hospital, so she was sent out at that time. During an interview on 05/08/24 at 1:59 PM, the DON stated it was her expectation that she and the NP were notified any time a resident had a change-in-condition. She stated she had not been notified of Resident #1's constipation until the night before she requested to go to the hospital, 04/24/24. She stated it was the nurses' responsibility to notify the NP of any changes to ensure she was involved in all aspects of the residents' care. Review of the facility's Change of Condition Policy, revised 12/2023, reflected the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. 1. If, at any time, it is recognized by any of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to): . - Change in output (bowel or bladder) including amount, color, consistency, odor, or frequency. . 7. The Interdisciplinary team (IDT) shall collaborate with the attending physician .