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	07/16/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by facility staff for one (Resident #2) of ten residents reviewed for abuse, in that: The facility failed to protect Resident #2 from physical abuse by LVN A on 6/3/2024 when LVN A pulled on Resident #2's wheelchair causing him to fall to the ground. This failure placed residents at risk of not being protected from abuse, neglect, or exploitation. Findings included: Review of Resident #2's face sheet dated 7/14/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (progress memory loss disease), Type 2 Diabetes (blood sugar disorder), Asthma (breathing disorder), Dementia (memory loss disorder), Hypertension (high blood pressure) and Osteoporosis (bone density disorder). Review of Resident #2's quarterly MDS assessment reflected a BIMS score of 11 suggesting mild cognitive impairment. Further review of the MDS reflected Resident used a wheelchair for ambulation ad could ambulate independently with his wheelchair. Review of Resident #2's care plan with a canceled date of 6/27/2024 reflected the focus: Potential for injury as [Resident #2] was moved back and fell to his left knee, a goal of: [Resident #2] will have no adverse effects from being moved backward and falling to his knee thru next review; and interventions: Complete head to toe assessment if possible - Resident has decline, Monitor for any changes in behavior or mood, Monitor for pain to knees, Refer to psychology and psychiatry for services for follow up. Review of Resident #2's progress notes dated 6/3/2024 at 6:44 p.m. by the DON., reflected Observed [LVN A] talking loudly to resident [Resident #2] saying you cannot be back here; you cannot tell me what to do. and pulling on resident's wheelchair. Resident was seen resisting and fell down on his knees. NP notified. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a progress note dated 6/3/24 at 6:53 p.m., reflected Resident # 2 refused a skin assessment, denied pain and said he wanted to rest. Resident #2 refused to allow staff to touch him at all. During an interview on 7/12/2024 at 12:00 p.m., the AAD stated on 6/3/2024, Resident #2 was behind the nurses station. LVN A attempted to remove Resident #2 from behind the nurse's station by yanking on his wheelchair from behind. As a result of the yanked force, Resident #2 fell out of his wheelchair and landed on his knees. Nursing staff attempted to assess Resident #2, but he refused. The AAD stated Resident #2 did not have any injuries and did not go to the ED. The AAD stated LVN A was suspended immediately, and an investigation was started. The AAD stated later when they went back and viewed the facility video of the event the decision was made to terminate LVN A. When the Investigator asked to see the video, the AAD notified investigator that the recording device only saved 7 days' worth of video, and they no longer had the video. The AAD stated he and his corporate nurse both reviewed the video and would supply statements as to what they witnessed on the video. Multiple attempts made to contact LVN A to be interviewed were not successful . Review of the Facility investigation report reflected LVN A was suspended on 6/3/2024. There was no statement from LVN A in the facility report. Review of facility Counseling notice dated 6/6/2024 reflected reasons why counseling action is necessary: On 6/3/24 after review of the video, it was determined that the employee physically removed resident from behind the desk causing the resident to fall out of his wheelchair to the ground. Employee then proceeded to yell at the resident Review of witness statement dated 7/24/2023 by AAD reflected in the video, the resident [Resident #2] was viewed seated in his wheelchair and propelling his wheelchair behind the 1-00 hall nurse' station. The staff member [LVN A] seated behind the desk stated You can't be back here the resident did not respond and remained behind the nurses' station. The staff member then walked behind the resident's wheelchair and began pulling on the chair from behind. The resident continued to try and move forward. The resident came out of the chair and fell on to his left knee. Review of witness statement dated 7/24/2023 by CN reflected Resident #2 was behind the nurse's station. The resident [Resident #2] was seen in a wheelchair, leaning forward, his right foot was in front and his left knee was flexed as he was wheeling into the nurses' station area. The nurse [LVN A] was then seen holding the wheelchair from behind and pulling the patient backward, as the patient was trying to move forward. As the employee was pulling the chair backward, the resident was noted to come out of his wheelchair onto his left knee and then the resident stood up. Review of facility onboarding records reflected a form indicating LVN A received training on Resident Rights which was signed by LVN A on 9/26/2023. Review of facility onboarding records/employee file reflected a form indicating LVN A received training on Resident Rights & Protections, Reporting and Preventing Abuse, Neglect and Mistreatment Notice and Texas Senate [NAME] 9 Advisement which was signed by LVN A on 9/24/2023 The date of hire for LVN A was 9/25/2023. All appropriate background checks were completed on 8/31/2023 including license check, criminal background checks and employability registry. The employee file reflected LVN A's date of termination as 6/6/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Abuse: Prevention of and Prohibition Against dated 4/2024 reflected: It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Facility staff are prohibited from taking, keeping, using or distributing photographs or video recordings of Facility residents in any manner that would demean or humiliate a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status. This includes using any type of equipment (e.g., cameras, smart phones, or other electronic devices) to take, keep, or distribute inappropriate photographs or recordings on social media. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation. This policy applies to all Facility staff including, but not limited to, employees, consultants, contractors, volunteers, students, and other caregivers who provide care and services to residents on behalf of the Facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections to the extent possible for one (Resident #1) of four residents reviewed for indwelling urinary catheters, in that: The facility failed to implement a batch order for daily catheter care when Resident #1 was admitted on [DATE] and failed to provide daily catheter care for Resident #1 from 7/2/2024 until 7/10/2024. This failure could place residents with indwelling urinary catheters at risk of sepsis, renal failure, urinary tract infections, and pain. Findings included: Review of Resident #1's face sheet dated 7/14/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: Cellulitis (bacterial skin infection), Chronic Kidney Disease, Morbid Obesity (severely overweight), Hypertension (high blood pressure), Congestive Heart Failure, Major Depressive Disorder (type of depression), Borderline Personality Disorder (mental health disorder), Tobacco use, Alcohol use and anxiety disorder. Review of Resident #1's MDS admission assessment dated [DATE] reflected a BIMS score of 9 suggesting mild cognitive impairment. Review of MDS Section H - Bladder and Bowel reflected resident had an Indwelling catheter and urinary continence was not rated, resident had a catheter Review of Resident #1's care plan dated 7/3/2024 reflected no Focus Area, Goal, or Interventions for an indwelling catheter. Review of Resident #1's care plan dated 7/12/2024 reflected a Focus Area for Indwelling Catheter with a goal of Will remain free of catheter related trauma through review date and Interventions to include position catheter bag below the level of the bladder and away from entrance room door, monitor and document input and output and monitor for signs and symptoms of pain, burring, blood-tinged urine .change in behavior, change in eating patterns. Review of nursing progress note dated 7/2/2024 at 5:37 p.m., by LVN B reflected Resident has a 16F Foley cath. Resident Foley is patent and draining properly. Review of NP admission assessment progress note with a date of service of 7/3/24 reflected under the heading Physical Exam, Genitourinary: no tenderness, Foley Indicating Resident #1 had a Foley Catheter in place. Review of Resident #1's progress notes dated from 7/2/2024 until 7/11/2024 reflected no progress notes indicating any catheter care was attempted or performed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's orders dated 7/12/2024 reflected an order dated 7/10/2024 to start 7/11/2024 Catheter care every shift. Monitor urethral site for s/s of skin breakdown, pain/discomfort, unusual odor, urine characteristic or secretions, catheter pulling causing tension. During an interview on 7/12/2024 at 1:20 p.m., the DON stated the facility uses batch orders for Foley catheter care. The DON stated the nurse that does the admission is responsible for making sure they are completed. The DON stated she did not put in the catheter care batch orders for Resident #1 until 7/10/2024 I should have done it but I didn't get to it. The DON further stated the nurses are still learning how to do batch orders but ultimately is responsible for making sure they get in and done. She stated she believed catheter care was being done even though there was no order, but she cannot prove this as there are no progress notes from the nurses to reflect the care was being done. She stated if catheter care is not done residents can get infections and become very sick. During an interview on 7/15/2024 at 9:10 a.m., the AAD stated he was not aware Resident #1 did not have orders put in at admission for catheter care and stated, that is unacceptable. During an interview on 7/15/2024 at 11:58 a.m., the AD stated her expectation is that staff will make sure new admissions are followed up on immediately as far as orders including Foley catheters. She stated it is the DON's responsibility to follow up and make sure orders are being done. She stated she is not sure how this was missed because she is currently out on maternity leave. When asked what could happen if catheter care is not provided, AD stated a plethora of things - infection control first and foremost, it could lead to infections a UTI could be the first thing. If it is not documented then the care didn't happen. During an interview on 7/15/2024 at 12:43 p.m., the Medical Director (MD) stated he came on as MD for the facility in January of 2024 and has reviewed the facility batch orders and is familiar with the orders. He stated he was not aware the batch orders for catheter care for Resident #1 were not done until 10 days after Resident #1 was admitted . He stated his expectations around indwelling catheters is nursing should ensure residents have Foley catheter care orders at admission. He stated he believed it was an oversight and does not believe there have been any issues with any other residents pertaining to catheter care. He stated if catheter care is not performed a resident could potentially get an infection or some other complication from their catheter; a resident could also get skin breakdown from it not being cleaned or if the catheter is leaking. During an interview on 7/15/2024 at 12:50 p.m., LVN B stated she was the nurse that completed the admission orders on Resident #1. LVN B stated the nurses were typically responsible for the medication orders and the ADON or DON were responsible for the batch orders. She stated they have not had an ADON since the end of June, so the DON would have been responsible for the batch orders. She stated she has never received any training on how to input batch orders which would include orders for Foley catheter care. LVN B stated if catheter care is not done a Resident could potentially get an infection, have compromised skin integrity, the catheter could be dislodged and could not be patent. During an interview on 7/16/2024 at 1:16 p.m., the AAD stated they were not able to locate any in-service records for nursing staff on completing batch orders in EMR to include orders for catheter care, but they would be rectifying that right away. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy Indwelling Urinary Catheter Care dated 12/2023 reflected Policy - it is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort and decrease the risk of infection.