

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 02/17/2026
NAME OF PROVIDER OR SUPPLIER Wellington Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that the resident received adequate supervision and assistance with devices to prevent accidents for 1 (Resident #1) of 6 residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not elope from the facility on 1/10/2026, Resident #1 eloped was found in the alley behind the facility, attempting to get to the end of the alley where a coffee shop was located. This failure could result in serious injuries to residents and potentially death. The noncompliance was identified as PNC. This failure resulted in an identification of an (IJ) Immediate Jeopardy on January 10th, 2026, at 11:06 am. The IJ template was provided to the ADM and DON on February 17th, 2026, at 05:05 pm. The IJ was removed on January 11th, at 08:30 am, due to the facility implementing interventions to ensure the safety of the residents. A record review on February 17th, 2026, of Resident #1's face-sheet reflected that Resident #1 was a 60year-old-male who was admitted to the facility on [DATE] and re-entered on 11/06/2025 with diagnoses of cerebral infarction, chronic obstructive pulmonary disease, mild intermittent asthma, hemiplegia and hemiparesis, aphasia, and depression. Record review of Resident #1's quarterly MDS dated [DATE], reflected that Resident #1's BIMS score was a 01 and he was not interview able due to severe cognitive impairment. Record review of Resident #1's care plan dated 11/12/2025 reflected that Resident #1 had potential for behavioral problems and impulsiveness. The care plan also reflected that Resident #1 was an elopement risk with history of elopement from previous nursing facility. Interventions were assessing fall risk, redirect, document wandering behaviors, and provide structured activities. During an observation on February 17th, 2026, of the back patio, it was noted that the entire back is in a secure locked area with a long alleyway directly in the back. Interview on 02/12/26 at 12:56 p.m., the DON revealed that Resident #1 is a special resident. She stated that staff previously brought him coffee from the local coffee shop (across the street). On January 10th, 2026 (a Saturday), there was a fill-in receptionist who forgot to get Resident #1, coffee and he became agitated. She stated that she was told that while the facility housekeeper was outside throwing trash out, Resident #1 caught the door and rolled his wheelchair out of the gate towards the alley. The DON stated that he did not make it to the coffee shop and had not left the premises. A psych eval was completed by ADON who also completed an elopement, skin and pain assessment. No harm or injury was found. The DON stated that Resident #1 was on 1 on 1 until psych was able to see him. (48hours later) In-services on making sure the door is closed and locked, emergency drill, elopement risk (Code pink), and where the elopement binder is kept and the nurse station. Interview on 02/17/26 at 09:52 a.m., the facility's housekeeper revealed after taking some trash out to the dumpster she failed to ensure that the gate locked behind her. She stated once she returned to the 100 hall another resident told her that a resident had escaped she stated she immediately yelled code Pink and ran outside. She stated once she arrived outside, she noticed a nurse was already outside talking with Resident #1.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455637	Facility ID: 455637 If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>She stated she was in-serviced on what to do if a resident escapes, personnel counseling and making sure she was aware of what code to yell out if she sees a resident elope. She stated that she was informed to stay with a resident if she was to see one trying to elope and to call for the aid. She also stated the facility had the gate lock repaired so that it would click once closed. Interview on 02/17/26 at 2:23 p.m., LVN A revealed that on 1/10/2026 when she arrived outside, she noticed Resident #1 attempting to cross the alley. She stated she attempted to redirect Resident # 1 and have him return to the facility. She stated he then became agitated and aggressive and hit her in the face. She stated she called for other staff to assist and Med Aid A came to help, and they returned Resident # 1 to the facility without injury. LVN A stated she completed a range of motion assessment but was unable to complete a head-to-toe assessment due to his previous aggression with her. He was then placed on 15min checks until he was cleared by a psych doctor on 01/12/2026. Record review on 02/17/26 of progress note completed on 1/10/2026 by the ADON reflected that on 1/10/2026 she completed a head- to -toe assessment, change in condition, smoking evaluation and elopement risk assessment for Resident #1. Interview on 02/17/26 at 2:43 p.m., CMA A revealed that a resident told her that Resident #1 had gone out of the back gate. She stated that she then went outside to see which resident it was. CMA A stated that she saw Resident #1 in the back alley. She then said that she went after him, when she and LVN A made it to him, he locked his chair and became combative. She said that Resident #1 was upset because the staff could not get him coffee. She stated that he was swinging and he hit LVN A in the mouth on accident. She said that Resident #1 cannot use words, so he was angry and trying to explain himself. She said that her and LVN A tried to calm him down, eventually Resident #1 allowed them to push him back into the building. CMA A said that after the incident all staff completed abuse and neglect, elopement, making sure that the gates are closed and locked and deescalation in-service. Interview on 02/17/26 at 2:59 p.m., the Maintenance Manager revealed that he was on the 300 hallway when he was told that while the housekeeper was throwing away garbage, she did not lock the gate behind her. Due to this Resident #1 was able to get out of the gate and found in the alley. The maintenance manager stated that he in-serviced the housekeeper on elopement and making sure the gate was locked behind her. He revealed that he also gave the housekeeper verbal counseling. He said that the housekeeper has never left the gate open before or since the incident. The maintenance manager stated that he also called a company to ensure that the gate was secure and that it would close right behind the person and lock. Review of the Elopement Policy dated 06/2018 indicated:It is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement[TW15]. A record review on 02/17/26 of the facilities self-report revealed that the wander guard system had been approved to be installed in the facility.Record review revealed that the facility completed the following in-services:- De-escalation, elopement, elopement binder location and ensure that the gate closes completely and locks signed by all staff.- Door checks come out documented by the maintenance manager once a week.-Quiz on elopement behavior.-Positioned a staff to sit at the back door 7 days a week from 7am to 7pm.-In the process of having a wander guard installed</p>		