

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675945	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/07/2025
NAME OF PROVIDER OR SUPPLIER  Wellington Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1506 Childress St Wellington, TX 79095	

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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</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

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to establish and follow a written policy on permitting residents to return to the facility after being hospitalized for 1 of 5 residents (Resident #1) reviewed for transfer/discharge. The facility did not allow Resident #1 to return to the facility after evaluation and treatment at a Psych Hospital due to the resident potentially still having aggressive and physical behaviors towards others. This deficient practice could place residents at risk of being discharged and not allowed to return to the facility causing a disruption in their care and services and potential decline in health. Findings included: Record review of Resident #1's face sheet, dated 6/24/25, revealed that Resident #1 was a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of Alzheimer's disease with early onset (a progressive neurodegenerative disorder that primarily affects the brain, causing a gradual decline in cognitive function, including memory and thinking skills), muscle weakness, urinary tract infection, dementia in other diseases classified elsewhere (a general term for a decline in mental ability that significantly impacts daily life, encompassing various conditions like Alzheimer's disease and vascular dementia), moderate with agitation, schizoaffective disorder (a mental illness characterized by a combination of psychotic symptoms, like hallucinations and delusion, and mood disorder symptoms, such as depression or mania), depressive type, anxiety disorder, neuralgia and neuritis (pain caused by damaged or irritated nerves and/or inflammation of nerves), folate and thiamine deficiencies (not enough folic acid and vitamin B1), depression, chronic pain, hypertensive heart disease without heart failure, reflux, benign prostatic hyperplasia with lower urinary tract symptoms (prostate gland enlargement that can cause urination difficulty), shortness of breath, restlessness and agitation and hyperlipidemia (high levels of fat particles (lipids) in the blood. Record review of Resident #1's MDS, dated [DATE], revealed that Resident #1 had a BIMS score of 3, which indicates the Resident #1 had severe cognitive impairment. Resident #1 had a functionality of limited assistance needed with the exception to shower/bathing and dressing, which required assistance by one staff. Resident #1 wandered. Record review of Resident #1's care plan, dated 2/14/25, revealed the following:-Care Plan Focus: Resident #1 requires antidepressant medication - date initiated 2/14/25 Care Plan Goal: Resident #1 will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Date initiated 2/14/25, target date 5/15/25. Care Plan Interventions/Tasks: -Educate the resident/family caregivers about risk, benefits and the side effects and/or toxic symptoms of antidepressant drugs being given.-Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations.-Monitor/document/report to MD prn ongoing signs and symptoms of depression, unaltered antidepressant medications: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. All initiated 2/24/25-Care Plan Focus: Resident #1 uses antianxiety medications - date initiated 2/14/25 Care Plan Goal: Resident #1 will be free from discomfort or adverse reactions related to antianxiety therapy through the review date. Date initiated 2/14/25, target date 5/15/25. Care Plan Interventions/Tasks:-Educate the resident/family/caregiver about risks, benefits and the side effects and/or toxic symptoms of antianxiety drugs being given. -Give antianxiety medications ordered by physician. Monitor/document side effects and effectiveness: antianxiety side effects: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Paradoxical side effects: mania Hostility and rage, aggressive or impulsive behavior, hallucinations.-Monitor/record occurrence of for target behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others - document pre facility protocol.-Resident #1 is taking antianxiety medications which are associated with an increased risk of confusion, amnesia, loss of balance and cognitive impairment that looks like dementia, falls, broken hips and legs. Monitor for safety. -If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc.-Monitor for fatigue and weight loss.-Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. All initiated</p>		