STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675945	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Care Center	1506 Childress Street 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)
F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received food prepared in a form designed to meet individual needs for 1 (Resident #1) of 5 residents reviewed for dietary needs.The facility failed, on the evening of 04/30/26, to serve Resident #1 a mechanically soft meal as ordered by her physician. The noncompliance was identified as PNC. The IJ began on 04/30/26 when Resident #1 was served the wrong texture of meal and choked on a meatball. The facility had corrected the noncompliance before the investigator entered the facility.This failure could place residents at risk of aspiration, choking, and/or weight loss. It resulted in Resident #1 chokeding on a meatball and requiring the Heimlich maneuver to restore her ability to breathe.Findings Included:Record review of Resident #1's admission record dated 05/13/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dysphagia oralpharyngeal phase (swallowing disorder that makes it difficult or unsafe to move food from the mouth to the esophagus).Record review of Resident #1's quarterly MDS assessment completed on 03/17/26 revealed a BIMS score of 11 which indicated moderately impaired cognition. Section K Swallowing/Nutritional Status revealed Resident #1 received a mechanically altered diet while a resident.Record review of Resident #1's care plan completed on 03/17/26 revealed Resident #1 was at risk for malnutrition and was to receive her diet as ordered by the physician. She was also care planned for choking. Her diet was to be followed as prescribed. Resident #1 was care planned for Regular diet, mechanical soft texture. Staff were to serve diet and snacks as ordered.Record review of Resident #1's order summary report dated 05/13/26 revealed the following order with start date of 06/04/25, Regular diet Mechanical Soft texture, Regular consistency.Record review of Resident #1's progress notes revealed the following notes:A note by ADON on 04/02/25 at 05:34 PM resident chocking [sic] at meal time. ambulance call and back thrush [sic] and heimlich [sic] maneuver were done.A note by ADON on 04/02/25 at 05:41 PM ambulance and sheriff department arrived and took. ambulance left with reesident [sic] at 1855 (06:55 PM).A note by RN A on 04/30/26 at 05:30 PM Choking event at Dining Room.Occurred while eating.The resident choked on: meatHeimlich maneuver was performed. The object was expelled.Cognition/Behavior at Time of Event: Oriented/no problem.Alerted to resident choking, back thrust performed and then the Heimlich, object ejected. Resident in no distress. Resident stable. Assessment completed all within normal limits. Lungs sounds clear to auscultation.Initial Treatment/New Orders: n/aResident Statement: Thankful that I was here, and that she wanted to finish her tea.Record review of a trauma informed assessment dated [DATE] revealed Resident #1 had no trauma concerns.Record review of Resident #1's speech therapy evaluation and plan of treatment dated 05/03/26 revealed Resident #1 was to work with speech therapy on chewing, swallowing, eating, jaw and tongue range of motion and strengthening.Record review of the Provider Investigation Report including all supporting documents dated 05/08/26 and filled out by ADM revealed RN A and [NAME] B were suspended pending facility's investigation. All staff were trained on abuse, neglect, and exploitation as well as choking and importance of charge nurse checking meal trays for accuracy. Dietary staff were trained on (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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	proper serving techniques and ensuring the residents were served the correct diet. An out of cycle QAPI was completed on the incident. All residents were reviewed for swallowing difficulty and for diet orders.During an interview on 05/13/26 at 09:10 AM DON stated Resident #1 was served a regular texture meal for the evening meal on 04/30/26 rather than the mechanically soft meal ordered by her physician. DON stated RN A was supposed to check the meal ticket on the tray with the plate prior to allowing the tray to leave the kitchen, but RN A was new to the facility and did not realize that was her responsibility. DON stated RN A and [NAME] B were both suspended due to RN A not checking the plate for accuracy and [NAME] B not checking the ticket prior to serving the plate. DON stated, The cook is supposed to serve the right diet, but it is the responsibility of the nurse to ensure it is correct. She stated she had been trained since the incident, and she would now go with new nurses to ensure they understood how to check the trays against the meal tickets. She stated the facility referred Resident #1 to speech therapy to ensure she did not have any unidentified issues with swallowing. She stated, following the incident on 04/30/26, all staff were trained on recognizing and responding to choking as well as the importance of nurses ensuring correct diet before trays were delivered.During an interview on 05/13/26 at 09:41 AM DA C stated he did not have anything to do with putting food on trays. He stated that was the responsibility of the cook. He stated he did not think there would be a negative outcome if a resident with a mechanically soft diet order was served a regular texture meal. He stated he had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an interview on 05/13/26 at 09:55 AM BOM stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in choking or aspiration and the resident could stop breathing which could result in harm or death. She stated she had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an interview on 05/13/26 at 09:56 AM RN A stated she was hired on 04/21/26 and she was not trained on checking meal trays against meal tickets to ensure residents received the correct diet. She stated on 04/30/26 she was alerted by someone (she could not remember which staff member) that Resident #1 was choking. RN A stated she went to Resident #1 and determined she was choking and attempted 2-3 back thrusts. She stated she then had two CNAs assist Resident #1 from her wheelchair so she (RN A) could perform the Heimlich maneuver on Resident #1. She stated she performed the Heimlich maneuver 3-4 times before the meatball came up. RN A stated Resident #1 did not seem distressed and wanted to remain in the dining room to finish her tea. RN A stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in harm or death. She stated she had been retrained on nursing competencies including monitoring meal trays for accuracy following the incident on 04/30/26.During an interview on 05/13/26 at 10:00 AM SNA E stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in the resident choking. She stated if no one was around to notice, the resident could die. She stated she had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an interview on 05/13/26 at 10:02 AM HSK I stated of serving a resident who was supposed to have a mechanically soft diet a regular texture meal, I mean, worst case scenario they could perish. She stated she had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an interview on 05/13/26 at 10:05 AM SNA D stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in choking, harm, or death. She stated she had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an interview on 05/13/26 at 10:06 AM CNA F stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could cause the resident to choke or aspirate. He stated it could lead to death. He stated he had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an observation and interview on 05/13/26 at 10:10 AM Resident #1 stated she remembered choking recently but it wasn't a bad one. She stated she choked previously and had to go (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the hospital.During an interview on 05/13/26 at 10:13 AM HSK H stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in death if she aspirates the food and is unable to breathe and somebody doesn't get there on time. He stated he had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an interview on 05/13/26 at 10:19 AM CNA G stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in choking or death. She stated she had been trained on what to do if a resident was choking and on ensuring residents were served the correct diet.During an interview on 05/13/26 at 10:23 AM ADON stated she was one of the nurses who trained RN A. She stated she trained RN A on checking meal trays against meal tickets. She stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in choking and/or death. She stated she had been trained on ensuring new nurses understood the importance of monitoring meal trays for accuracy.During an interview on 05/13/26 at 10:25 AM DON stated serving a resident who was supposed to have a mechanically soft diet a regular texture meal could result in death.During an attempted interview on 05/13/26 at 12:09 PM CNA J was called. No answer.During an attempted interview on 05/13/26 at 12:11 PM a text was sent to CNA J. She did not reply.During an interview on 05/13/26 at 12:21 PM SNA D stated she was in the dining room on 04/30/26 when Resident #1 choked. She stated CNA J saw Resident #1 choking and yelled for RN A. SNA D stated RN A attempted back thrusts. SNA D stated she and CNA J helped pick Resident #1 out of her wheelchair so RN A could perform the Heimlich maneuver.During an interview on 05/13/26 at 01:39 PM [NAME] B stated it was her fault Resident #1 received a regular diet on the evening of 04/30/26. She stated she was rushing as she was reading the meal tickets. She stated she had been retrained on reading meal tickets to ensure the meal matches the diet order. [NAME] B stated serving a resident who was supposed to have a mechanically soft diet, a regular texture meal could result in choking.During an interview on 05/13/26 at 01:50 PM DM stated [NAME] B was working for the second time alone on the evening of 04/30/26. She stated she thought [NAME] B was rushing as she read through the meal tickets and that was how Resident #1 received a regular diet instead of a mechanically soft diet. She stated she had trained all of her kitchen staff on checking trays for diet accuracy since the incident. She stated serving a resident who was supposed to have a mechanically soft diet, a regular texture meal could result in choking or the resident getting food stuck in their throat, leading to infection.Record review of an in-service by DON for RN A dated 05/01/26 revealed she was trained on abuse, neglect, exploitation, reviewing meal trays for accuracy, and nursing competencies.Record review of an in-service by ADM for [NAME] B dated 05/02/26 revealed she was trained on abuse, neglect, exploitation, and serving correct diets to residents.Record review of an in-service by ADM for DON dated 05/01/16 revealed she was trained on meeting with all new nurses prior to the new nurse being on the floor alone to check all nurse competencies including monitoring meal trays to ensure accurate diet.Record review of an in-service by DM for all kitchen staff dated 05/01/26 revealed they were trained on ensuring resident diets were followed and served correctly.Record review of an in-service by DON for ADON and the two other nurses who trained RN A dated 05/01/26 revealed they were trained on nurse proficiency audit and nurse competencies which included checking meal trays against meal tickets to ensure accuracy.Record review of an in-service by DON for all staff dated 05/01/26 revealed they were trained on abuse, neglect, exploitation, meal service and choking hazards, and the nurse's responsibility to check meal trays for diet accuracy.Record review of an out of cycle QAPI meeting regarding Resident #1 choking on an inaccurate diet revealed a date of 05/01/26.Record review of form titled Nursing Competencies signed by RN A on 05/01/26 revealed the following: . Dietary-The nurse checks tray tickets for accuracy .Record review of facility policy titled Diet Orders/Diet Manual and dated 2012 revealed no mention of cooks serving accurate diets or charge nurses ensuring accurate diets.Record review of an undated facility policy titled Eating, Assistive/Complete revealed the following: . 1. Become familiar with the resident's diet and any special modifications, . 2. Review (continued on next page)

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