

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 01/30/2026
NAME OF PROVIDER OR SUPPLIER Wellington Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen when they failed to: A. Ensure facility staff wore hair restraints and beard guards while in the kitchen. B. Ensure stored and cooked food was properly labeled, dated and covered. C. Ensure menu substitutions were documented. D. Ensure expired foods were discarded. These failures placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings included: In an interview and record review on 1/28/26 at 10:20 am, the DM produced the menu titled Menu Manager -Weekly menu for the facility for the Fall Winter-week 3 dated 12/5/25. The DM stated the planned menu for lunch was Rueben sandwiches, onions and peppers, potato salad, fried pickles, and chocolate turtle cake. She stated there were 4 residents with pureed diets. The DM stated these food items were all the foods to be served for the week for the residents. In an observation of the freezer on 1/28/26 at 10:20 am revealed the following: 1 box of frozen bread, open to air and unsecured. 1 bag of ham, not in original box, open to air, 3 bags of hamburger patties, not in original box, no label or date. In an observation of the kitchen cabinets on 1/28/26 at 10:35 am, the following was observed: Lemon pie filling mix, open to air. Sweet Cream Pancake mix, open to air. 2 boxes of cream of Wheat, open to air. In an observation and interview on 1/28/26 at 11:30 am revealed the DM's hair had been sticking out of her hair net in the back, and [NAME] B had a beard cover on his beard but did not cover the full extent of his beard on the sides of his face or his moustache. [NAME] B stated he was aware his beard and moustache needed to be covered. He stated the beard cover would not stay up over his moustache. He stated the consequences of not having his facial hair covered would be food borne illness and his hair could fall into the food. The DM stated she was not aware of her hair sticking out of the hairnet and pushed the hair back into the hairnet. She stated she was aware the beard cover did not fit [NAME] B and she had ordered different beard covers for him but had not received them. In an interview and observation of the foods being pureed for the lunch meal, there had been no fried pickles pureed. At the conclusion of the purees this writer asked why the fried pickles were not pureed. The DM stated the residents with a pureed diet were getting green beans instead of fried pickles. She stated she did not think the fried pickles would puree correctly so she had decided to puree green beans instead. In an observation on 1/28/26 at 12:10 pm [NAME] B had a beard cover on his beard. The beard cover did not cover [NAME] B's full extent of his beard or his moustache. In an observation of the noon meal on 1/28/26 at 12:30 pm, residents with pureed diets were not served pureed fried pickles for the lunch meal. The residents with a pureed diet were served green beans instead. In an observation of the freezer on 1/29/26 at 10:45 am revealed the following: 1 box of frozen cookie dough, unsecured and open to air. 1 box of biscuits, unsecured and open to air, 1 box of hamburger patties, unsecured and open to air. 1 bag of rolls, with a use by date of 1/19/26. 1 bag of cauliflower, with a use by date of 1/19/26. 1 bag of Brussel sprouts with a use by date of 1/26/26. 1 bag of fish with a hole in the bag, not in original box, open to air. In an interview on 1/29/26 at 2:02 pm the RD stated she had not trained the current DM, but the DM had been trained by the previous RD. She stated she expected all foods to be labeled and dated in the kitchen as well as sealed securely to be sure the food had not been exposed to air. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675945
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She stated she expected all expired foods to be discarded. She stated she expected all menu substitutions to be documented on the menu substitution list. The RD stated she expected hairnets, and beard covers to be worn and to cover all hair. She stated the consequences of all issues would be food borne illness. In a record review on 1/30/26 at 8 :00 am of the facility menu substitution list for the past 3 months, the substitution of green beans for fried pickles on the lunch meal for residents on a pureed diet served 1/28/26 had not been documented. In an interview on 1/30/26 at 8:50 am, the DM stated she had been trained by the dietician in running the kitchen and she had trained staff to label, date and keep foods closed to air. She stated she expected all staff to label date and close all foods to air as the food was used. She stated she had not been aware this had not been done. The DM stated she was not aware the freezer had several food items that were expired, and she would throw them out. The DM stated she was aware all staff had to keep hair, moustache and beards covered while in the kitchen. She stated she had been aware the beard cover did not cover [NAME] B's beard and moustache very well. She stated that food borne illness could result from all these issues. Record review of the facility policy titled ' Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices' dated 2001 documented: Hairnets and beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. Record review of the facility's policy titled, 'Food Storage and Supplies' dated 2012, documented:Opened packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. Record review of the facility's policy titled, ' Food Safety' dated 2012, documented:Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated, and stored properly. Perishable foods shall be used within 7 days or less. Record review of the facility's policy titled, ' Dietary Food Service Personnel Policy and Procedures ' dated 2012 documented:Hairnets or hats covering the hairline are worn at all times. [NAME] guards are required for facial hair. Record review of the facility's policy titled, ' Left Over Foods' dated 2012, documented:Leftover foods shall be refrigerated, dated, labeled and properly covered after meal service.Record review of the facility's policy titled, ' Storage Refrigerators ' dated 2012, documented:Food must be covered when stored, with a date, label, identifying what is in the container. Record review of the facility's policy titled, ' Infection Control ' dated 2012, documented:Clean hair is required. It is to be covered with an effective hair restraint. Facial hair is to be closely trimmed and is to be covered with a hair restraint. Record review of the facility's policy titled, ' Nutrient Retention of Foods' dated 2001, documented: Record review of the facility's policy titled, ' Menus ' dated 2012, documented:Menus are planned to meet the Recommended Dietary Allowances of the Food and Nutrition al Board. Alternates will be planned and recorded. Alternates will be of comparable nutritive value, and the alternate food shall come from the same food group. If any meal served varies from the planned menu, the change and the reason for the change shall be noted on the substitution log. The menus will be prepared as written using standardized recipes.Record review of the facility's policy titled, ' Menu Substitution Form ' dated 2012, documented:The DM will be responsible for making sure the menu substitution form is completed when items on the menu must be substituted. Menu Substitution Form should be filled out on every menu substitution. Substitutions must be of equal value as the item to be substituted (ie. Meat for meat, vegetable for vegetable)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure within 14 days after the facility determined, or should have determined, that there was a significant change in the resident's physical or mental condition for 1 of 16 residents (Residents #5) reviewed for comprehensive assessments. The facility failed to complete a significant change MDS for Resident #5 within 14 days of 12/30/2024-the date she elected to receive hospice care. This failure could place residents at risk of not receiving coordinated and appropriate care between the nursing facility and hospice provider. Findings Included: Record review of Resident #1's admission record dated 01/29/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (brain disorder that destroys memory and thinking skills), history of falling, muscle weakness, Dementia (decline in cognitive function) and generalized anxiety disorder. Resident #5's hospice was listed under primary payer on the admission record. Record review of Resident #5's latest MDS Assessment which was an Annual completed on 10/30/2025. Section C reflected a BIMS of 03, which indicated severe impaired cognition. Section O reflected Resident #5 was receiving hospice care while a resident. Record review of the MDS Summary section in Resident #5's EHR revealed no Significant Change in Status Assessment was completed within 14 days of hospice election on 12/30/2024 nor at any time following the hospice election. Record review of Resident #5's care plan, latest revision on 12/26/2025, reflected Resident #5 had a terminal prognosis which required hospice. Terminal illness date initiated on 12/30/2024. Record review of Resident #5's active physician orders revealed admit to hospice no start date, revision date on 01/29/26. Record review of Resident #5's progress notes dated 12/30/2024 revealed Resident #5 was admitted to Hospice. Record review of Resident #5's Facility Notification of Hospice Admission/Change paperwork dated 12/30/2024 confirmed Resident #5's hospice enrollment. During an interview on 01/29/2026 at 3:23 PM, the MDS LVN stated she had worked for the facility for an extended period but did not provide a specific date. She stated the RAI was the policy she followed for completing MDS assessments. The MDS LVN stated she completed the Annual MDS on 01/07/2025 and stated she did not realize she needed to complete a Significant Change in Status Assessment when a resident elected to receive Hospice Care. The MDS LVN confirmed the 01/07/2025 Assessment should not have been an Annual but a SCSA. The MDS LVN stated a possible negative outcome for not completing an accurate MDS Assessment would be a lapse in care. During an interview on 01/30/2026 at 10:00 AM, the DON stated the policy used in completing MDS assessments was the RAI. She stated she was not familiar with how to complete an MDS Assessment or the time frames. The DON stated the MDS LVN was responsible for completing the assessments timely and correctly. During an interview on 01/30/2026 at 10:09 AM, the Corp RN stated when a resident elected hospice, A Significant Change in Status Assessment was required. Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025, reflected the following: An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (CNA A) of 4 staff observed for infection control. -CNA A did not perform hand hygiene properly while performing catheter care for Resident #7. This deficient practice has the potential to affect residents by exposing them to care that could lead to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene. Findings included: Record review of Resident #7's face sheet revealed he was a [AGE] year-old male resident admitted to the facility originally on 12/06/24 and readmitted on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that commonly affects men as they age, often causing bothersome urinary symptoms), and flaccid neuropathic bladder (a type of neurogenic bladder characterized by weak bladder muscle (detrusor muscle) that cannot contract prop, leading to seer underactivity, high-capacity retention, and overflow incontinence), Record review of Resident #7's last MDS revealed a quarterly assessment completed on 01/25/26 with a BIMS of 05 indicating he was severely cognitively impaired, he had a functionality of requiring substantial/maximal assistance with his toileting hygiene, and he required an indwelling catheter. Record review of the care plan with admission date of 01/07/26 for Resident #7 revealed the following: Focus:Resident is on enhanced barrier precautions r/t catheter due to obstructive and reflux uropathy (the structural or functional hindrance of normal urine flow causing backpressure). Revision on 01/14/26 Record review of the Order [NAME] Report printed 1/29/2026 with Active Orders as of: 1/29/2026 for Resident #7 revealed the following order:- Change Foley Catheter using _16_ fr 10__ml bulb one time a day starting on the 14th and ending on the 14th every month. Active 12/03/2025. During an observation on 01/29/2026 at 09:55 AM CNA A cleaned Resident #7's perineal area and Resident #7's catheter to include the tubing then CNA A noted he did not have enough wipes. CNA A removed his gloves, then removed more wipes from the wipe container with his ungloved hands. CNA A then washed his hands and put on new gloves. CNA A then used the wipes he removed with his ungloved hands to clean the catheter tubing one more time, assisted rolling Resident #7, and then cleaned Resident #7's buttocks and rectal area. CNA A then touched the new brief and stated, I messed up. CNA A then removed his gloves, washed his hands, put on new gloves, used the same brief he touched with the contaminated gloves, and placed the brief on Resident #7. During an interview on 01/29/2026 at 10:18 AM CNA A reported he cleaned Resident #7's perineal area and catheter, then removed his gloves and retrieved more wipes with his ungloved hands. CNA A reported this contaminated the wipes he used because he had not washed his hand yet. CNA A reported he exposed Resident #7 to infection, especially a UTI or worse. CNA A reported he did touch the new brief with dirty gloves after wiping Resident #7's catheter then rectal area and placed the contaminated brief on Resident #7 exposing him again to a UTI or worse. CNA A reported he was asked to complete the catheter care for this survey because he was a recent graduate CNA and had been recently trained in his course. During an interview on 01/30/2026 at 10:20 AM the DON reported she expects her staff to perform hand hygiene when gloves are dirty, especially with incontinent or catheter care. The DON reported improper hand hygiene could result in the resident getting an infection which can result in irritation of their skin. The DON reported the facility was going to retrain all staff on hand hygiene. During an interview on 01/30/2026 at 10:41 AM the Corp RN reported she expects staff to perform hand hygiene prior to starting a resident care such as catheter care, when moving from the dirty to the clean part of catheter care, and after completing catheter care. The Corp RN reported that if the hand hygiene was not performed properly then contamination could result. Record review of the facility provided training titled Catheter Care provided to staff on 10/28/2025 by (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON revealed CNA A was trained on the following: Catheter Care Procedure: 16. Gently was, rinse, and dry around the juncture of the catheter. 19. Remove gloves. 21. Wash hands. Record review of the facility provided training titled Catheter Care provided to staff on 09/30/2025 by the DON revealed CNA A was trained on the following: Handwashing Record review of the facility provided policy titled Fundamentals of Infection Control Prevention 2019 manual, revealed the following: A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. Hand Hygiene - Before and after direct resident contact. - Upon and after coming in contact with a resident intact skin. - after removing gloves. Gloving - Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hand can become contaminated during removal of gloves. Failure to change gloves between resident contact is an infection control hazard. Record review of the facility provided policy titled Perineal Care effective 05/11/2022, revealed the following: Important Points - Always perform hand hygiene before and after glove use.		