| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676103 | A. Building<br>B. Wing | 04/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wells Ltc Nursing & Rehabilitation | 46 May Street<br>Wells, TX 75976 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818<br><br>Based on observation, interview and record review, the facility failed to ensure the right to be free from abuse was provided for 2 of 12 residents reviewed for abuse. (Resident #1 and Resident #3) in that:<br><br>The facility failed to protect Resident #1 from Abuse on [DATE] when Resident #2 stuck his hand into Resident #1's shirt and groped her breast.<br><br>The facility failed to protect Resident #3 from Abuse on [DATE] when Resident #4 pushed Resident #3's wheelchair over and hit him in the face.<br><br>The noncompliance was identified as PNC. The past noncompliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.<br><br>This failure could place residents at risk of injury, pain, hospitalization , and a diminished quality of life.<br><br>Findings included:<br><br>1. An admission record dated [DATE] revealed Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of metabolic encephalopathy and secondary diagnoses of stage 3 pressure ulcer of sacrum, chronic kidney disease, and rhabdomyolysis (disorder of muscle breakdown). An MDS dated [DATE] revealed she had a BIMS of 7 which indicated severe cognitive impairment. She was dependent on staff for most ADLS, and she was always incontinent of both bowel and bladder. Resident #1 expired in the facility on [DATE].<br><br>A closed record comprehensive care plan for Resident #1 indicated she had impaired cognitive function or impaired thought processes related to diagnosis of metabolic encephalopathy. Interventions were in place to engaging resident in simple, structured activities, and keeping resident's routine consistent to decrease confusion.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An admission record dated [DATE] indicated Resident #2 was a [AGE] year-old male with a primary diagnosis of Alzheimer's disease and secondary diagnoses of vascular dementia (altered cognition), hemiplegia (weakness on one side of the body), and major depressive disorder. An MDS dated [DATE] indicated a BIMS was not conducted due to resident being rarely or never understood. He was dependent on staff for assistance putting on/taking off footwear, upper and lower body dressing, shower/bathing; he required maximum assistance with personal hygiene and toileting hygiene; he required setup assistance with eating and oral hygiene. He was continent of bowel and bladder.<br><br>A comprehensive care plan dated [DATE] for Resident #2 revealed he had potential to demonstrate physical behaviors related to poor impulse control and was transferred to the men's secured unit following groping Resident #1's breast.<br><br>During an observation and interview on [DATE] at 10:52 a.m. Resident #2 was observed sitting in his wheelchair in his room. He appeared clean and well-groomed with no offensive odors and had no visible marks, bruising, or skin tears. Resident #2 said he put his hand inside Resident #1's shirt and touched her breast. He said he had no prior relationship with Resident #1, and she had not given him consent to touch her. He said he does not know why he touched her breast.<br><br>During an interview on [DATE] at 9:45 a.m. the ADM said Resident #1 was sitting in her geri chair (specialized recliner) by the nurse's station when Resident #3 rolled his wheelchair up beside her and stuck his hand inside her shirt. ADM said the incident was witnessed by several staff members and they intervened immediately, separating residents. ADM said she watched the security camera footage and confirmed the incident did happen. The ADM said Resident #2 was transferred to the secured men's unit following the incident.<br><br>Review of a witness statement from ADM dated [DATE] given after reviewing facility camera revealed Resident #2 rolled his wheelchair beside Resident #1, reached over with his left hand, and touched her. Resident #1 grabbed his arm and started to push it away when staff intervened.<br><br>Review of a witness statement from the Social Worker following an interview of Resident #1 after the incident. The witness statement revealed Resident #1 responded yeah when asked if a man had recently reached under her shirt and touched her breast. Resident #1 responded I think he should have been decked when asked if the incident left her emotionally upset.<br><br>2. An admission record dated [DATE] indicated Resident #3 was a [AGE] year-old male readmitted to the facility on [DATE] with a primary diagnosis of major depressive disorder with psychotic symptoms and secondary diagnoses of dementia and psychotic disorder (disconnection from reality) with delusions. An MDS dated [DATE] revealed he had a BIMS of 11 which indicated moderately impaired cognition. He required moderate to substantial assistance for all ADLs except eating, which required setup/cleanup assistance.<br><br>A comprehensive care plan dated [DATE] for Resident #3 indicated he had exhibited aggressive behaviors including hitting the secure unit door, yelling, and cursing at staff, going through other residents' belongings, and attempting to wake residents up. Interventions were in place including encouraging facility involvement, recognizing resident stressors, and provide resident with as many options for control over his care as possible. He was transferred to a behavioral health facility on [DATE].<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An admission record dated [DATE] indicated Resident #4 was a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's Disease and secondary diagnoses of bipolar disorder and unspecified psychosis. An MDS dated [DATE] revealed a BIMS had not been conducted due to resident being rarely/never understood. He was dependent on staff for personal hygiene and toileting hygiene; he required moderate assistance for upper body/lower body dressing and putting on/taking off footwear; he required supervision for oral hygiene; he required setup assistance for eating. He was always incontinent of bowel and bladder.<br><br>A comprehensive care plan for Resident #4 indicated he had a history of exhibiting aggressive behaviors toward others and had been previously referred to a behavioral health facility. The same care plan indicated he required psychotropic medications for diagnosis of Mood Changes/Behavior management and took Risperidone.<br><br>During an observation and attempted interview on [DATE] at 10:30 a.m. Resident #4 was sitting in the day room on the men's secured unit, he appeared clean and well-groomed with no offensive odors and had no visible marks, bruising, or skin tears. Resident #4 did not respond to questions and could not be interviewed due to cognitive impairment.<br><br>During an interview on [DATE] at 1:30 p.m., the ADM said she reviewed the facility camera and observed Resident #4 walking down the hallway, Resident #3 was going in the opposite direction of same hallway in his wheelchair. She said the video showed Resident #3 moved his wheelchair in front of Resident #4 which blocked his path. ADM said Resident #4 lifted Resident #3's wheelchair and tilted it backwards until it fell . She said Resident #3 was lying on his back, still in the wheelchair, and tried to kick Resident #4. She said Resident #4 bent down and punched Resident #3 in the nose. The ADM said following the incident both residents were separated, assessed, notifications were made, and both residents were placed on one-to-one observation until they were transferred to a behavioral health facility for evaluation. ADM said QAPI (Quality Assurance and Performance Improvement) had met concerning resident to resident altercations and the facility provided additional training to staff as well as re-evaluated roommate pairings on the men's secure unit.<br><br>Requested to view facility camera recordings of incidents; the facility did not provide recordings.<br><br>Review of an incident report dated [DATE] for Physical Aggression completed by LVN A indicated Resident #3 had an injury, redness to his nose, because of the altercation with Resident #4.<br><br>Facility took appropriate actions to correct the non-compliance prior to surveyor entry and there was no current non-compliance due to:<br><br>Facility took immediate action following the incidents including separating, assessing, and notifying.<br><br>Resident #1 expired.<br><br>Resident #2 was moved to the mens unit.<br><br>In-services were conducted.<br><br>QAPI meetings conducted following each incident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of QAPI Committee Report dated [DATE] which discussed topics Abuse, Neglect, and Misappropriation.<br><br>Review of QAPI Committee Report dated [DATE] which discussed topics Reporting Abuse, Neglect and Misappropriation and Resident to Resident Abuse.<br><br>Review of in-service dated [DATE] titled Identifying Sexual Abuse and Capacity to Consent.<br><br>Review of in-service dated [DATE] titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program.<br><br>Review of in-service undated titled Resident Rights<br><br>Review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised on [DATE] indicated the following: .<br><br>The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:<br><br>1. Protect residents from abuse, neglect, exploitation, and misappropriation of property by anyone including, but not necessarily limited to:<br><br>a. Facility staff;<br><br>b. Other residents;<br><br>c. Consultants;<br><br>d. Volunteers;<br><br>e. Staff from other agencies;<br><br>f. Legal representatives;<br><br>g. Friends;<br><br>h. Visitors; and/or<br><br>i. Any other individual |