STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676103	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wells Ltc Nursing & Rehabilitation	46 May Street 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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure residents the right to be free from abuse and neglect for 8 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7 and Resident #8) of 8 residents reviewed for abuse and neglect.The facility neglected to ensure enough staff to monitor the residents in the male secure unit which lead to the resident-to-resident abuse.The facility failed to prevent Resident #2 from abusing Resident #1 on 6/25/2025 when Resident #2 pushed Resident #1 down on the floor causing a fracture to the left 5th toe. The facility failed to prevent Resident #5 from abusing Resident #3 on 7/13/2025 when Resident #5 hit Resident #3 in the head twice.The facility failed to prevent Resident #4 from abusing Resident #3 on 7/30/2025 when Resident #4 slapped Resident #3 on the right side of the face from behind.The facility failed to prevent Resident #6 from abusing Resident #5 on 8/28/2025 when Resident #6 hit Resident #5 in the face.The facility failed to prevent Resident #7 from sexually abusing Resident #8 on 9/02/2025 causing Resident #8 to be admitted to the hospital. An IJ was identified on 9/03/2025. The IJ template was provided to the facility on 9/03/2025 at 3:36 PM. While the IJ was removed on 9/04/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place all residents in the facility at risk for injuries, hospitalization and severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being.Findings Included: 1. Record review of Resident #1's facility's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses include Alzheimer's Disease with history of psychotic disorder (problem with thinking and delusions), and Hyperlipidemia (high cholesterol). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 (resident is rarely to never understood), indicating she was severely cognitive impaired. She required supervision to limited assistance with one person assist for dressing, toilet use, personal hygiene and required supervision with ambulation. Record review of Resident #1's care plan dated 03/14/2025 revealed Resident #1 is an elopement risk/wanderer as evidenced by impaired safety awareness, with interventions that included, distract resident from wandering by offering pleasant diversions, structured, activities, food, conversation, television, book. 2.Record review of Resident #2's facility's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses include dementia with, severe, with other behavioral disturbance, delusional disorders, major depressive, lack of coordination, anxiety disorder and age-related cognitive disorder. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 (resident is rarely to never understood), indicating she was severely cognitive impaired. She required supervision to limited assistance with one person assist for dressing, toilet use, personal hygiene and required supervision with ambulation. Record review of Resident #2's care plan dated 01/03/2025 revealed Resident #2 is an elopement risk/wanderer as evidenced by impaired safety awareness, with interventions that included, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Record review of Resident #1 and #2's incident report dated 06/25/2025 revealed the incident description that Resident #1 was standing over Resident #2 who was sitting on the couch. Resident #1 said something to Resident #2 and resident # 2 shoved Resident #1 causing her to fall. Both residents were assessed for injuries. A skin tear to the left elbow and a raised area was noted to the left side of resident #1's head. An xray revealed age indetermination fifth digit proximal phalanx head fracture (fracture to left fifth toe) for resident #1. Record review of witness statement from CNA F dated 6/25/2025 revealed on the day of 6/25/2025. I saw [Resident #2] push [Resident #1], causing [Resident #1] to fall down. [Resident #2] was brought to the nurse's station and sat there during the process of notifying the psych doctor and then was placed on Q15 monitoring. During an interview on 9/4/2025 at 11:49 AM with RN L she said she had worked with Resident #1 and Resident #2, in the past and was not at work during the time of the incident between Resident #1 and Resident #2. She said Resident #1 was on hospice and not aggressive and was mostly bedridden. She said Resident #2 was normally not aggressive and to push someone was out of her normal character . 3. Record review of Resident #3's facility's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included: Dementia (progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), cognitive communication deficit

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 8 of 8 residents reviewed for accidents and supervision. (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8) The facility failed to adequately provide supervision to prevent Resident #2 from abusing Resident #1 on 6/25/2025 when Resident #2 pushed Resident #1 down on the floor causing a fracture to the left 5th toe. The facility failed to adequately provide supervision to prevent Resident #5 from abusing Resident #3 on 7/13/2025 when Resident #5 hit Resident #3 in the head twice. The facility failed to adequately provide supervision to prevent Resident #4 from abusing Resident #3 on 7/30/2025 when Resident #4 slapped Resident #3 on the right side of the face from behind. The facility failed to adequately provide supervision to prevent Resident #6 from abusing Resident #5 on 8/28/2025 when Resident #6 hit Resident #5 in the face. The facility failed to adequately provide supervision to prevent Resident #7 from sexually abusing Resident #8 on 9/02/2025 causing Resident #8 to be admitted to the hospital. The facility failed to adequately supervise residents on the secured unit to maintain safety and to prevent resident to resident altercations. An IJ was identified on 9/03/2025. The IJ template was provided to the facility on 9/03/2025 at 3:36 PM. While the IJ was removed on 9/04/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed all residents in the secured unit at risk of injury and death. Findings included: 1.Record review of Resident #1's facility's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnosis include Alzheimer's Disease with history of psychotic disorder (problem with thinking and delusions), and Hyperlipidemia. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 (Resident is rarely to never understood), indicating she was severely cognitive impaired. She required supervision to limited assistance with one person assist for dressing, toilet use, personal hygiene and required supervision with ambulation. Record review of Resident #1's care plan dated 03/14/2025 revealed Resident #1 is an elopement risk/wanderer as evidenced by Impaired safety awareness, with interventions that included, distract resident from wandering by offering pleasant diversions, structured, activities, food, conversation, television, book. 2.Record review of Resident #2's facility's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnosis include dementia with, severe, with other behavioral disturbance, delusional disorders, major depressive, lack of coordination, anxiety disorder and age-related cognitive disorder. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 (Resident is rarely to never understood), indicating she was severely cognitive impaired. She required supervision to limited assistance with one person assist for dressing, toilet use, personal hygiene and required supervision with ambulation. Record review of Resident #2's care plan dated 01/03/2025 revealed Resident #2 is an elopement risk/wanderer as evidenced by Impaired safety awareness, with interventions that included, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Record review of Resident #1 and #2's incident report dated 06/25/2025 revealed incident description that resident #1 was standing over resident #2 who was sitting on the couch. Resident #1 said something to resident #2 and resident # 2 shoved resident #1 causing her to fall. Both Residents was assessed for injuries, skin tear to left elbow and raised area noted to left side of resident #1's head. Xray revealed age indetermination fifth digit proximal phalanx head fracture (fracture to left fifth toe) for resident #1. Record review of witness statement dated 6/25/2025 CNA F stated on the day of 6/25/2025. I saw Resident #2 push Resident #1, causing Resident #1 to fall down. Resident #2 was brought to the nurse's station and sat there during the process of notifying the psych doctor and then was placed on Q15 monitoring. During an interview on 9/4/2025 at 11:49 AM with RN L she said she had worked with Resident #1 and Resident #2, in the past and was not at work during the time of the incident between Resident #1 and Resident #2. She said Resident #1 was on hospice and not aggressive and was mostly bedridden. She said Resident #2 was normally not aggressive and to push someone was out of her normal character. 3. Record review of Resident #3's facility's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis included: Dementia (progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), cognitive communication deficit (difficulty

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, when reviewing the facility for sufficient staffing for 2 of 4 hallways (Hallways A and B). The facility failed to adequately staff the A and B hallway (secured units) to prevent resident to resident abuse.The facility failed to ensure A Hall (male secured unit) had sufficient staffing to prevent Resident #2 from abusing Resident #1 on 6/25/2025 when Resident #2 pushed Resident #1 down on the floor causing a fracture to the left 5th toe. The facility failed to ensure A Hall (male secured unit) had sufficient staffing to prevent Resident #5 from abusing Resident #3 on 7/13/2025 when Resident #5 hit Resident #3 in the head twice.The facility failed to ensure A Hall (male secured unit) had sufficient staffing to prevent Resident #4 from abusing Resident #3 on 7/30/2025 when Resident #4 slapped Resident #3 on the right side of the face from behind.The facility failed to ensure A Hall (male secured unit) had sufficient staffing to prevent Resident #6 from abusing Resident #5 on 8/28/2025 when Resident #6 hit Resident #5 in the face.The facility failed to ensure A Hall (male secured unit) had sufficient staffing to prevent Resident #7 from sexually abusing Resident #8 on 9/02/2025 causing Resident #8 to be admitted to the hospital.An IJ was identified on 9/03/2025. The IJ template was provided to the facility on 9/03/2025 at 3:36 PM. While the IJ was removed on 9/04/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of injuries, abuse, severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being. Findings included:Record review of Resident #1's facility's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnosis include Alzheimer's Disease with history of psychotic disorder (problem with thinking and delusions), and Hyperlipidemia (high cholesterol). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 (Resident is rarely to never understood), indicating she was severely cognitive impaired. She required supervision to limited assistance with one person assist for dressing, toilet use, personal hygiene and required supervision with ambulation. Record review of Resident #1's care plan dated 03/14/2025 revealed Resident #1 is an elopement risk/wanderer as evidenced by Impaired safety awareness, with interventions that included: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Record review of Resident #2's facility's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnosis include dementia with, severe, with other behavioral disturbance, delusional disorders, major depressive, lack of coordination, anxiety disorder and age-related cognitive disorder. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 (Resident is rarely to never understood), indicating she was severely cognitive impaired. She required supervision to limited assistance with one person assist for dressing, toilet use, personal hygiene and required supervision with ambulation. Record review of Resident #2's care plan dated 01/03/2025 revealed Resident #2 is an elopement risk/wanderer as evidenced by Impaired safety awareness, with interventions that included: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Record review of Resident #1 and #2's incident report dated 06/25/2025 revealed that Resident #1 was standing over Resident #2 who was sitting on the couch. Resident #1 said something to resident #2 and resident # 2 shoved resident #1 causing her to fall. Both Residents were assessed for injuries. A skin tear to left elbow and raised area noted to the left side of Resident #1's head. An x-ray revealed age indeterminate fifth digit proximal phalanx head fracture (fracture to left fifth toe but unable to determine the age of the fracture) for Resident #1. A Record review of a witness statement from CNA F dated 6/25/2025 stated, on the day of 6/25/2025. I saw Resident #2 push Resident #1, causing Resident #1 to fall down. Resident #2 was brought to the nurse's station and sat there during the process of notifying the psych doctor and then was placed on Q15 monitoring. 3. Record review of Resident #3's facility's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included: Dementia (progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), cognitive communication deficit (difficulty communicating), Alzheimer's disease