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	02/24/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interviews and record review, the facility failed to determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 1 of 7 residents (Resident #1), reviewed for drug diversion.The facility failed to prevent the misappropriation of Resident #1's hydrocodone-acetaminophen 5-325 mg (formerly known under the brand name Norco, this combination medication containing 5 mg of hydrocodone [an opioid analgesic] and 325 mg of acetaminophen [also known as Tylenol] is used to treat pain).This failure could place residents at risk for not receiving their prescribed medications, unrelieved pain, and decreased quality of life.Findings include:1.Record review of Resident #1's face sheet dated [DATE] indicated he was [AGE] years old, admitted to the facility on [DATE] and expired in the facility on [DATE] with diagnoses including: obstructive hydrocephalus (buildup of cerebrospinal fluid inside the brains ventricles), malignant neoplasm of brain (brain cancer), dementia (decline in memory, thinking and behaviors).Record review of the MDS dated [DATE] indicated Resident #1 was rarely/never understood. The MDS indicated Resident #1 BIMS was not assessed. The MDS indicated Resident #1 was dependent on staff with bed mobility, transfers, and toilet use.Record review of the care plan dated [DATE] indicated Resident #1 had complaints of pain. The care plan interventions included monitor/document for side effects of pain medication.Record review of the active physician order with a start date of [DATE] detailed Resident #1 was to be administered hydrocodone-acetaminophen 5-325 mg 1 tablet two times a day related to malignant neoplasm of brain.Record review of the provider investigation report (PIR) dated [DATE] detailed that the medication hydrocodone/acetaminophen 5/325mg for Resident #1 went missing between [DATE]-[DATE]. The medication was given to the ADON after Resident #1's discharge/death on [DATE]. The ADON logged the medication on her destruction list, paired the count sheet and medication together using a rubber band and placed it in the locked closet. On [DATE] the Pharmacist and DON pulled medications to destroy them and the hydrocodone/acetaminophen 5/325mg for Resident #1 that was listed on the destruction log was not located with the rest of the narcotics. During an interview on [DATE] at 10:10 am, the ADON said drug destruction was her responsibility and she was the only person who had a key to the closet. She said Resident #1 expired in the facility on [DATE], she said she had taken Resident #1's 43 tablets of hydrocodone/acetaminophen 5/325mg and logged it on the drug destruction log then placed the count sheet with the medication in the closet in her office. She said she did not place the medication in the safe in the closet, she said she locked the 1 door handle on the outside of the closet door. She said on [DATE] she was out that day and the DON did the drug destruction with the Pharmacist and that was when it was discovered that the medication was missing. She said at the time of the drug diversion the nurses would bring her discontinued narcotic medications, she would log them and place them in the closet not in the safe. She said she was trained to put the medications in the closet not in the safe. She said the door to her office could be bumped and would (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	easily open. She said during the investigation of the missing medication, the DON had tried the closet door and you could easily get a butter knife in and open the door. She said her office door would be open at times when she got to work in the morning. She said she knew some of the staff would use her fridge and her bathroom at all hours when she was not at the facility. She said since she had taken the ADON position that was the only missing medication that she was aware of.During an interview on [DATE] at 12:24 pm, the DON said on [DATE] the ADON was out and she went to help the pharmacist do drug destruction and they discovered the missing hydrocodone/acetaminophen 5/325mg. She said it had been logged but was missing from the closet. She said after her investigation she believed someone had manipulated the locks on the ADON door and closet and was able to get in. She said the medications were not in the safe at the time of the drug diversion. She said anyone could bump there hip on the door and the door would come open. She said the closet handle door lock could easily be popped with a butter knife. She said they did not watch the facility camara's to see if they could tell who took the narcotics because staff was allowed to go in the ADON office at all hours because there was a fridge in that office. She said since the drug diversion they replaced the plate on the ADON office door, placed the additional pad lock on the closet door, and started putting narcotics in the safe inside the closet. She said staff are no longer allowed to go into the ADON office to use the fridge anymore. During an interview on [DATE] at 9:10am, The administrator said at the time of the drug diversion the ADON office door was not secure and was able to be easily opened by bumping the door with your hip. She said the drug destruction closet had 1 door handle lock. She said during the investigation of the drug diversion the DON was able to get a butter knife from the kitchen and easily break into the drug destruction closet. She said at the time of the drug diversion the narcotic medications were not being stored inside the locked safe. She said the new ADON had started logging the narcotics for destruction and that is how they were able to determine if there were missing narcotics. She said the prior ADON did not log the narcotics at the time of placing them in the closet but only logged them when the pharmacist was at the facility to do the drug destruction. She said the facility could not determine if there were any other missing narcotics because they were not being logged as they were received so anyone could take them without the facility knowing. Record review of the Facility Drug Destruction Log dated [DATE] indicated 43 tablets of Resident #1's hydrocodone/acetaminophen 5/325mg were Not destroyed, Not found in in lock box, DON will research signed by the DON and the Pharmacist.Review of the facility policy and procedure titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program revised April of 2021, stated Develop and implement policies and protocols to prevent and identify: .theft, exploitation or misappropriation of resident property.Review of the facility policy and procedure titled Controlled Substances, dated [DATE], stated 1. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises. 3. Controlled substances are stored in the medication room in a locked container, separate from containers for any non-controlled medications. Review of the facility policy and procedure titled Discarding and Destroying Medications, dated [DATE], stated 1. All unused controlled substances are retained in a securely locked area with restricted access until disposed of.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to 1 of 1 medication destruction storage closet reviewed for medication storage.The facility failed to ensure the medication destruction closet was secured and was unable to be accessed by unauthorized personnel between 12/04/2025 through 1/15/2026.This failure could put residents at risk of unauthorized use of medication and accidental ingestions/use of an unprescribed medication.Findings included:During an observation on 2/23/2026 at 9:10 am, the medication destruction closet located inside the ADON office revealed the door to the ADON office was open with no staff present. The medication destruction closet had a pad lock that was locked, a door handle that was locked and a deadbolt lock that was not locked. Inside of the medication destruction closet revealed a safe that contained the narcotic medications waiting to be destroyed. The safe was not permanently affixed and was able to be picked up and moved.During an interview and observation on 2/23/2026 at 12:24 pm, the DON unlocked the pad lock and the door handle on the medication destruction closet door which contained the narcotic safe. The DON opened the narcotic safe and tilted the safe forward which indicated the narcotic safe was not permanently affixed to the shelf. During an interview on 2/23/2026 at 9:10 am the ADON said she had been trained by the previous ADON for about 1 week. She said all she knew was the medications were supposed to be in the closet locked but did not know they needed to be in the locked safe with the safe permanently affixed to the shelf. Review of the facility policy and procedure titled Controlled Substances, dated April 2019, stated 1. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises. 3. Controlled substances are stored in the medication room in a locked container, separate from containers for any non-controlled medications. Review of the facility policy and procedure titled Discarding and Destroying Medications, dated November 2022, stated 1. All unused controlled substances are retained in a securely locked area with restricted access until disposed of. Review of the facility policy and procedure titled Medication Labeling and Storage dated February 2023 indicated: .7. Controlled substances (listed as schedule II-V of Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.