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	09/05/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record reviews the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 20 residents (Residents #16, 20, and 39) reviewed for call lights. 1. The facility failed to ensure the call light in Resident #16's bathroom located on the men's secured unit were not wrapped around the support bar and were reachable from the floor on 9/03/2024. 2.The facility failed to ensure the call light in Resident #20's bathroom and rooms [ROOM NUMBER] located on the women's secured unit were not wrapped around the support bar and were reachable from the floor on 9/03/2024. 3. The facility failed to ensure the call lights in the bathrooms of rooms [ROOM NUMBER] located on the womens secured unit were reachable for Resident #39 on 9/03/2024. These failures could affect residents who used their call light or desire to use the call light and place them at risk of not being able to notify staff of their needs. Findings: 1.Record review of a facility face sheet dated 9/4/24 for Resident #16 reflected that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: dementia and Parkinsonism (clinical syndrome characterized by tremor, bradykinesia (slowed movements), rigidity, and postural instability). Record review of a Quarterly MDS dated [DATE] for Resident #16 reflected that he had a BIMS score of 10, which indicated that he had a moderate cognitive impairment. He required partial/moderate assistance with transfers. He was frequently incontinent of bowel and bladder. Record review of a comprehensive care plan dated 8/22/23 for Resident #16 reflected that he was at moderate risk for falls related to confusion with an intervention that read .the resident needs a safe environment with: .a working and reachable call light . (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/3/24 at 9:31 am revealed room [ROOM NUMBER] on the men's secured unit had a call light in the restroom which appeared to be approximately 6-7 inches and would be too short to have been reachable from the floor. During an observation and interview on 9/3/24 at 9:39 am revealed room [ROOM NUMBER] on the men's secured unit had a call light in the restroom that was wrapped around the grab bar. Resident #16 was in the room sitting up on the side of the bed. Resident #16 said that he does use the restroom by himself. He denied any falls. He said if he did fall, he would need to be able to reach the call light. Resident #16 was observed propelling self into the restroom to use the toilet. During an observation on 9/3/24 at 9:48 am revealed room [ROOM NUMBER] on the men's secured unit was observed to have a call light wrapped around the grab bar in the restroom. During an interview on 9/3/24 at 9:53 am CNA D said the call light in the restrooms should not be wrapped around the grab bars. She said she did not know why, but she knew they shouldn't be. She was unaware of who was responsible for the call lights in the resident's restrooms. She said Resident #16 did use his restroom independently. During an interview on 9/3/24 at 9:58 am Housekeeper said maintenance was responsible for the call lights in the resident's restrooms. 2.Record review of a facility face sheet dated 9/04/24 reflected Resident #20 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of phantom limb syndrome with pain and unsteadiness on feet and resided on the women's secured unit. Record review of a comprehensive care plan dated 4/11/22 reflected Resident #20 had bladder incontinence at times and encourage fluids during the day to promote prompted voiding responses, has an ADL self-care performance deficit r/t loss of limbs, digits, cognitive deficits, and had an actual fall and to use her call light for help. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #20 had a BIMS of 15 indicating intact cognition and required moderate assistance with toileting. During an interview on 9/03/24 at 9:15 am Resident #20 said she resided in room [ROOM NUMBER] , used her bathroom and would pull her call light if she needed help. 3. Record review of a facility face sheet dated 9/04/24 indicated Resident #39 was a [AGE] year-old female that admitted to the facility 3/30/23 with diagnosis of dementia and resided on the women's secured unit. Record review of a comprehensive care plan dated 4/04/23 indicated Resident #39 was a high fall risk related confusion and to be sure the resident's call light was within reach and encourage the resident to use it. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #39 could not complete BIMS testing and had memory problems, had severely impaired cognition and required supervision for toileting. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/03/2024 at 9:10 am on the women's secured unit, rooms 19- and 20's-bathroom call light was wrapped and tied in a knot to the support bar and room [ROOM NUMBER]'s-bathroom call light was tied in a knot and was approximately 3 feet from the floor. During an interview on 09/03/24 at 9:20 AM CNA E said she had worked at the facility for [AGE] years. She said the residents in room [ROOM NUMBER] and 20 did not use their bathroom but Resident # 20 in room [ROOM NUMBER] used her bathroom and Resident # 39 wandered and would use all the bathrooms on the hall. She said she had never thought about checking the cords to ensure they could be reached from the floor and pulled if needed. She said she guessed that it would be the aides and maintenance directors' responsibility to check the call lights. She said if the light was not able to be pulled then staff wouldn't know they needed help. During an observation on 9/03/24 at 11:00 am revealed Resident #39 was observed wandering the hall and in and out of rooms on the women's secured unit. During an interview on 09/04/24 at 3:46 pm the maintenance director who said he had been at the facility for almost a year. He said he was responsible for checking all the call lights in the facility. He said he checked the call lights weekly to see that they worked, were not wrapped around the grab bar, or tied in knots. He said if he found a call light wrapped or tied, he corrected them and then advised the staff not to wrap or tie them in knots. He said if the light was wrapped or tied the resident could not use in case of an emergency because the string would not pull to set off the alarm. He said if the alarm could not go off the resident could possibly not get help. During an interview on 09/05/24 at 9:14 am the Administrator who said the maintenance director was responsible for checking all call lights in the facility and should be doing checks monthly and as needed. She said the CNA's should also be monitoring and making sure the call lights were able to be pulled for activation but had not done any specific training on this prior to this event. She said the risk of the call light not being able to be activated could cause delay of services and expected call light cords to not be wrapped or tied and able to be pulled to alert staff of any needs. Record review of a facility policy titled Call System, Resident dated September 2022 reflected, .each resident is provided with a means to call staff for assistance from his/her bed, toileting/bathing facilities and from the floor .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 46273 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 3 of 16 residents reviewed for ADLs (Residents #3, Resident #19, and Resident #9). 1. The facility failed to ensure Resident #19's face and bed linens were clean when her eyes had drainage present to the corners of both of her eyes and when her bed linens were visibly dirty with brown stains and the comforter had dark brown stained substances on 9/3/2024. 2. The facility failed to ensure Resident #3 received timely incontinent care on 9/4/2024 when the resident was observed walking throughout the facility with wet pants. 3. The facility failed to clean or groom Resident #9 fingernails on 9/3/2024-9/4/2024. These failures could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity, and health. Findings included: 1. Record review of a face sheet for Resident #19 dated 9/4/2024 reflected she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's disease (brain disorder that causes memory loss, thinking problems and behavior changes) major depressive disorder (persistent feeling of sadness or loss of interest), heart failure (inability of the heart to pump effectively) and chronic kidney disease stage 4 (severe loss of kidney function). Record review a task schedule for September 2024 for Resident #19 reflected ADL bathing was done on q shift on Tuesday, Thursday, and Saturday and last time documented was on 9/3/2024 at 10:31 PM. Nursing rehab: dressing/grooming-resident will use washcloth to cleanse face and will brush teeth with set up help from staff x1 every shift was documented on 9/1/2024 and 9/2/2024, 9/3/2024 and 9/4/2024 were blank. Record review of a Quarterly MDS Assessment for Resident #19 dated 7/24/2024 reflected she had severe impairment in thinking with a BIMS score of 6. She required partial/moderate assistance with eating, oral hygiene, and personal hygiene. She was always incontinent of bladder and bowel. Record review of a care plan for Resident #19 revised on 4/8/2023 reflected she had an ADL Self Care Performance Deficit related to Alzheimer's disease. Interventions for bathing indicated she was totally dependent on staff to provide a bath 3 times weekly and as necessary. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 9/3/2024 at 9:29 AM revealed Resident #19 was in her room, in bed awake with the covers pulled up to her neck when Resident #19 said she had been at the facility for about a month. Her face had dried eye drainage on the inner corners of both of her eyes. Her comforter was visibly dirty. During an observation and interview on 9/3/2024 at 4:55 revealed Resident #19 was in her room, in bed dressed, dried eye drainage present to the corners of both of her eyes. She said she received her showers on Tuesday and Sunday and thought the staff changed her linens that day. The top sheet on her bed was hanging off the foot of the bed and visibly dirty with brown stains and the comforter still had dark brown stained substances all over. During an observation and interview on 9/3/2024 at 5:10 PM, CNA B was in the room with Resident #19 and said she assisted Resident #19 earlier that day and she wiped her face that morning. She said she had been employed at the facility for 2 weeks and worked 6am-6pm. She said she changed her linens after lunch that day. She said if linens were wet or soiled, they were supposed to change everything on the bed. She said after lunch that day, she did not change the fitted sheet on the bed and all she changed was the blanket that was underneath her buttocks. She observed the linens on the bed and said they were dirty along with the comforter. She said if she was a resident and depended on staff to provide care to her and the linens were dirty and her face was not clean, she would be mad. She said she did clean Resident #19 face that afternoon after lunch, but her eyes had been matted up for a couple of days. She said she was not sure if the nurse was aware or not. 2. Record review of an Admission Record dated 9/4/2024 for Resident #3 reflected he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of major depressive disorder (persistent sadness or loss of interest), mild intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently), and hypertension. Record review of a Quarterly MDS assessment dated [DATE] for Resident #3 reflected he had moderate impairment in thinking with a BIMS score of 10. He required supervision or touching assistance with toileting hygiene. He was always continent of urine and always incontinent of bowel. Record review of a care plan revised on 4/30/2023 for Resident #3 reflected he had a behavior related to wearing urine- soaked clothes, drying out urine-soaked clothes in his room and then wearing once dried. Interventions included if reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. Intervene as necessary to protect the rights and safety of others. He had an ADL Self Care Performance Deficit with interventions for toilet use he required staff assistance x1 to use the toilet. He had bladder incontinence with interventions to check every 2 hours and as required for incontinence. Change clothing prn after incontinent episodes. During an observation on 9/4/2024 at 7:50 AM revealed Resident #3 was walking down the hall wearing gray pants headed to the nurse desk where the Medication Aide was standing. Resident #3 asked the Medication Aide about his medications and the Medication Aide told him he would bring his medications to him in the dining room. The back of the resident's pants was dark in color and looked like they were wet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 9/4/2024 at 8:45 AM revealed Resident #3 was sitting in the dining room with his Best Friend. The Best Friend said she had been with the resident for 6-7 months from 8 am-10 am Monday-Friday. Resident #3 was listening to gospel inspirations. The Best Friend said when she visited the resident in the mornings, he was always dressed and would assist him with getting out clothes for him and the staff would put them on him. She said at times he would be wet from urine and was resistive to care. She said he understood when staff would tell him that his clothes were wet and would allow the staff to change him if needed. She said he wore briefs but would take them off and would remove his wet clothes and put them in the drawers in his room. She said he could go to the restroom on his own but at times would have accidents. During an observation and interview on 9/4/2024 at 10:20 AM revealed Resident #3 was in his room lying in bed with a light pink blanket being used as a under pad. There were not any linens on the bed. Resident #3 said they took them away because they were wet. He had a wet pair of pants lying on his over bed table in the room. Housekeeping staff entered the room and started sweeping the floor. Observation revealed Resident #3 was in bed wearing the same gray pair of pants from earlier that day (09/04/2024 at 7:50 AM) and they were wet. During an interview on 9/4/2024 at 10:25 AM HSK A said she had been at the facility for a few months and worked hall C where Resident #3 resided. She said Resident #3 stayed wet all the time and would have his wet clothes on the tables or in the drawers drying out. She said a lot of times there would not be any linens on his bed when she went into the room to clean. During an observation and interview on 9/4/2024 at 10:55 AM revealed Resident #3 was sitting on a couch in dining room watching tv and had on a different pair of pants that were blue in color. Resident #3 said the staff changed his pants because the other pants were wet. During an interview on 9/4/2024 at 10:58 AM CNA B said she was assigned to the hall for Resident #3 on today 9/4/2024. She said earlier that morning on 9/4/2024, she had to change his linens on his bed because they were wet, and his bed was soaked. She said he did not allow some of the staff to assist him with care. She said this morning on 9/4/2024, when his bed was wet, she did not put any linens back on the bed because the mattress was soaked and was letting it air out. She said she was not able to dry the mattress because they did not have enough towels at the time. She said the resident had accidents at times. CNA B said she was not aware the resident had gone back to bed earlier in the day after breakfast and his bed did not have any linens on the bed. During an interview on 9/4/2024 at 11:08 AM the DON who said Resident #3 would only allow certain people to assist with providing care to him. She said he was frequently wet and would refuse showers. She said the resident was easily redirected. She said they recently had an in-service regarding Resident #3 with staff as they were constantly having to tell the resident that his clothes were wet. She said he was ambulatory. She said they did have a problem recently with the facility not having enough towels and washcloths, but they purchased more and had not been told that they were low again. She said linens should be changed when they were soiled or when wet and on shower days. She said going forward she would provide more training to the staff as they have a lot of newer staff employed at the facility. She said she would hope that if she had a loved one or herself that they would get the care they needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/5/2024 at 9:20 AM, the Administrator who said linens should be changed as needed and on shower days. She said she purchased 2 cases of sheets about a week ago and told the staff if sheets were stained, they were told to let laundry know and not leave them there until they are washed. She said they have addressed to staff about Resident #3 and required them to redirect him a lot to change his clothes, he would wet himself and hang his clothes in his room to dry. She said going forward she would educate staff on all residents that were dependent to provide care and help them and would be doing checks to make sure that Resident #3 was not wet. She said her expectations were for the staff to follow their care plans and they should be redirecting Resident #3, bed should be kept clean and dry, and should be helping with the resident's appearance and making sure they were clean when going to bed. She said it would make her feel very bad and probably would not want to get out of bed and would be embarrassed. Record review of an in-service dated 4/20/2023 was conducted at the facility regarding Resident #3 that reflected when assigned to Halls C and D, once every shift a CNA was to go into the room of Resident #3 and obtain any dirty/soiled linen out of the dresser drawers and take to laundry to be washed. 3. Record review of a facility face sheet dated 9/4/24 for Resident #9 reflected that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Depression, dementia, and anxiety disorder. Record review of a Comprehensive MDS assessment dated [DATE] for Resident #9 reflected that he had a BIMS score of 7, which indicated that he had a severe cognitive impairment. Assessment indicated he had not had behaviors of rejecting care. He was dependent with personal hygiene. Record review of a comprehensive care plan dated 10/11/22 for Resident #9 reflected that he had an ADL self-care deficit and interventions included to .Check nail length and trim and clean on bath day and as necessary . During an observation on 9/2/24 at 9:21 am Resident #9 was observed in common area of men's secured unit in a wheelchair. He did not speak at this time. He was observed with long, dirty fingernails. During an interview on 9/3/24 at 9:25 am CNA D said the CNAs were responsible for keeping the resident's nails clean and groomed. During an observation on 9/3/24 at 12:00 pm revealed Resident #9 was observed in common area/dining room of men's secured unit. He was sitting at a table in his wheelchair waiting for lunch. He was observed with long nails. He kept fidgeting with them like he was trying to clean out from underneath them with his other nails. Multiple nails were observed to be dirty underneath with the third finger on his right hand observed with a black substance underneath. During an observation and interview on 9/4/24 at 10:10 am revealed Resident #9 was observed in common area of men's secured unit up in wheelchair He talked about serving in Vietnam and meeting [NAME] W. Bush. He was fidgeting with his nails while talking as if he was trying to clean them. His nails are still observed to be dirty with a black substance underneath several nails. When asked if his nails were bothering him, he said yes, they seem to be. When asked if he would like his nails cleaned and groomed, he said Yes, I would like them done when someone gets a chance to do it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/4/2024 at 11:25 AM DON said that CNAs should perform nail care on the residents anytime it was needed, but at least on bath days. She said residents could be at risk of scratches and skin tears if nail care was not done. During an interview on 9/5/24 at 9:18 am Administrator said she expected her staff to provide nail care according to what their care plan said and that residents could be at risk of scratching their skin and getting infections. Record review of a facility policy titled Fingernails/Toenails, Care of dated 2001, revised in February 2018 reflected .The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . and .Nail care includes daily cleaning and regular trimming . Record review of a facility polity titled Activities of Daily Living (ADLs), Supporting revised March 2018 reflected, .Residents who are unable to carry out daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); 7. The resident's response to interventions

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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. 43994 Based on interviews and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and follow a policy to provide pharmacy services in accordance with State and Federal laws or rules of the Drug Enforcement Administration for 1 of 12 months (January 2024) reviewed for pharmacy services. The facility failed to document the required number of 2 witness signatures for drug destruction on 1/5/2024. This failure could put residents at risk for misappropriation and drug diversion. Findings included: Record review of facility drug destruction records for the last 12 months (12/2023 to 8/2024) reflected that on 1/5/2024 the cover page and the attached page were only signed by the DON and the Pharmacist and did not include any additional witness signatures. During an interview on 9/4/2024 at 11:49 AM, the DON who said the drug destruction sheets were normally signed by the Pharmacist, ADON and herself. She said in January 2024 she did not have an ADON at that time. She said the drug destruction sheets needed the Pharmacist signature and 2 witness signatures and having 2 witnesses instead of 3 helped prevent the risk of a drug diversion. During an interview on 9/5/2024 at 9:20 AM, the Administrator who said she was not part of the drug destruction process in the facility. She said she only signed a form after it was completed and did not witness any of the destruction. She said she knew the sheets had to be signed by at least 2 nurse and was not aware that she could be a witness as well. She said there was a risk for drug diversion if they did not have the appropriate signatures on the drug destruction pages. Record review of a facility policy titled Discarding and Destroying Medications revised November 2022 reflected, .Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. 10. The medication disposition for controlled drugs record contains, as a minimum, the following information: i. Signature of witnesses . Record review of the Texas Administrative Code retrieved from https://texreg.sos.state.tx.us/ on 8/7/2024 reflected: .Dangerous drugs may be destroyed provided the following conditions are met . (C) The signature of the consultant pharmacist and witness(es) to the destruction and the method of destruction specified in subparagraph (B) of this paragraph may be on a cover sheet attached to the inventory and not on each individual inventory sheet, provided the cover sheet contains a statement indicating the number of inventory pages that are attached and each of the attached pages are initialed by the consultant pharmacist and witness(es) .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 46273 Based on observations, interviews, and record review, the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 5 of 5 residents (Residents #13, #25, #26, #36, and #42) reviewed for puree diets. The facility failed to prepare the pureed diet to the consistency required for Residents #13, #25, #26, #36, and #42 on 9/4/24. This failure could place residents who received pureed foods at risk of not having nutritional needs met by consuming foods that could cause choking and decreased meal intakes. Findings included: 1. Record review of a facility face sheet dated 9/3/24 for Resident #13 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Alzheimer's, aphasia (loss of ability to understand or express speech, caused by brain damage), and dysphagia (difficulty swallowing). Record review of a Quarterly MDS assessment dated [DATE] for Resident #13 reflected that he had a BIMS score of 9, which reflected that he had moderate cognitive impairment. He required supervision assistance with eating. Record review of a comprehensive care plan revised on 8/6/24 reflected that he had a swallowing problem, received a pureed diet and interventions included to follow diet as prescribed. Record review of a Physician's Order Summary Report dated 9/3/24 indicated the following diet order dated 9/6/23: .Regular diet, pureed texture . 2. Record review of a facility face sheet dated 9/5/24 for Resident #25 reflected that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: urinary tract infection and dysphagia (difficulty swallowing). Record review of a comprehensive MDS assessment dated [DATE] for Resident #25 reflected that had a BIMS score of 9, which reflected that he had moderate cognitive impairment. He was dependent with eating. Record review of a comprehensive care plan dated 9/26/23 for Resident #25 indicated that he was at risk for potential nutritional problems and interventions included to provide and serve diet as ordered. Record review of a Physician's Order Summary Report dated 9/5/24 for Resident #25 indicated that he had the following order dated 8/16/24: .No salt on tray diet, pureed texture . (continued on next page)

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Record review of a facility face sheet dated 9/6/24 for Resident #26 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Alzheimer's and dysphagia (difficulty swallowing). Record review of a Quarterly MDS assessment dated [DATE] for Resident #26 indicated that Brief Interview for Mental Status should not be completed due to resident being rarely/never understood. She had severely impaired cognition. She required partial/moderate assistance with eating. Record review of a comprehensive care plan dated 8/19/24 for Resident #26 indicated that she was at risk for nutritional problems and received a pureed diet. Interventions included to provide and serve diet as ordered. Record review of a Physician's Order Summary Report dated 9/6/24 for Resident #26 indicated that she had the following order dated 8/8/24 .Regular diet, pureed texture . 4. Record review of a facility face sheet dated 9/6/24 for Resident #36 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: acute pancreatitis (inflammation of the pancreas that causes abdominal pain and can affect other organs) and dysphagia (difficulty swallowing). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #36 indicated that Brief Interview for Mental Status should not be completed due to resident being rarely/never understood. She had severely impaired cognition. She required partial/moderate assistance with eating. Record review of a comprehensive care plan dated 8/19/24 for Resident #36 indicated that she had a potential for nutritional problem and received a puree diet. Interventions included to provide and serve diet as ordered. Record review of a Physician's Order Summary Report dated 9/6/24 for Resident #36 indicated that she had the following order dated 8/17/24: .No salt on tray diet, pureed texture . 5. Record review of a facility face sheet dated 9/6/24 for Resident #42 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Dementia, pneumonia (an infection in the lungs), and dysphagia (trouble swallowing). Record review of a Quarterly MDS assessment dated [DATE] for Resident #42 indicated that he had a BIMS score of 13, which indicated that he was cognitively intact. He required set up or clean up assistance with eating. Record review of a comprehensive care plan dated 8/12/24 for Resident #42 indicated that he had a potential for nutritional problem and received a pureed diet. Interventions included to provide and serve diet as ordered. Record review of a Physician's Order Summary Report dated 9/6/24 for Resident #42 indicated that he had the following order dated 4/27/24: .regular diet, pureed texture . (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 9/4/24 at 11:45 am revealed [NAME] F was pureeing foods for noon meal. She pureed the meat; she said it was still too grainy and pureed it again. After pureeing a second time, she said it was much better. Surveyor asked [NAME] F if they ever tasted the pureed foods for texture and she said that she did not. DM was also in kitchen and said that she did taste the food for texture as needed. DM nor [NAME] F tasted the meat after pureeing. During an observation and joint interview on 9/4/24 at 12:40 pm to 12:45 pm surveyors received test tray of regular and pureed foods. Pureed meat was visibly lumpy and had a chewy texture to it. Pureed greens were stringy in texture. Administrator and DM were both brought to room to taste puree food. Administrator said the texture was not smooth and DM said meat was too grainy and greens were stringy. DM said if pureed foods were not served at the correct texture, residents receiving puree diets could be at risk of choking. During an interview on 9/5/24 at 9:18 am Administrator said residents who need pureed diets could be at risk of swallowing issues and aspiration. She said they would be providing education to dietary staff to ensure pureed foods were served at the correct consistency going forward. She said she expected her staff to serve foods in the correct texture. During a telephone interview on 9/5/24 at 10:02 am Corporate Dietician said they check purees every time they come to facility. She said she expects a pudding like consistency without lumps. She said she had started an in-service yesterday (9/4/24) with the dietary staff for pureed foods. She said she expected the cooks to taste the pureed foods for texture before serving. She said residents requiring puree foods could be at risk of choking if served the wrong consistency foods. Record review of a facility policy titled Therapeutic Diets dated 2001 and revised October 2017 read .A therapeutic diet is considered a diet ordered by a physician, practitioner, or dietician as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: .d. Altered consistency diet . Record review of a Guidance Form for puree foods provided by facility and put out by International Dysphagia Diet Standard Initiative read .Pureed food for adults .do not require chewing .and .have a smooth texture with no lumps .

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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** 43994 Based on observations, interviews, and record review the facility failed to establish and 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 of 12 residents (Resident #15) and 1 of 5 staff (NA C) reviewed for infection control. NA C did not sanitize or wash her hands between glove changes when providing incontinent care to Resident #15 on 9/3/2024. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: Record review of an Admission Record dated 9/4/2024 for Resident #15 reflected she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of diverticulitis of intestine (an infection in the inside walls of the intestine), chronic kidney disease (gradual loss of kidney function), age related osteoporosis (a condition that results from aging when bone formation does not keep up with bone removal) and bipolar disorder (a mental health condition that causes extreme mood swings). Record review of a care plan revised on 8/16/2024 for Resident #15 reflected she had bowel and bladder incontinence and was at risk for skin breakdown. Interventions included incontinent and to check the resident every 2 hours and as required for incontinence. Record review of a Quarterly MDS assessment dated [DATE] for Resident #15 reflected she did not have any impairment in thinking with a BIMS score of 15. She required substantial/maximal assistance with toileting hygiene. She was always incontinent of bladder and bowel. During an observation on 9/3/2024 at 9:09 AM in the room of Resident #15 revealed CNA B and NA C were in the room to provide incontinent care. Both washed their hands in the bathroom and applied gloves. CNA B pulled down Resident #15's brief between her legs and NA C removed wipes from the container. NA C removed a wipe and wiped down the left inner thigh and placed the wipe in the trash. NA C took another wipe and wiped down the right inner thigh and placed it in the trash. NA C took a wipe, and wiped down the middle of the vagina from front to back and placed the wipe in the trash. CNA B rolled Resident #15 onto her right side, and NA C removed a wipe and wiped her rectum from front to back and placed the wipe and brief in the trash. NA C applied barrier ointment to Resident #15's buttocks and removed her gloves and placed them in the trash. NA C placed clean gloves on her hands without washing or sanitizing them. NA C placed a clean brief underneath the resident's buttocks and secured it and Resident #15 was repositioned in her bed. NA C removed her gloves and placed them in the trash. NA C placed clean gloves on her hands without washing or sanitizing them and picked up a soda for the resident and poured it into a cup that was on the over bed table. CNA B removed her gloves and placed them in the trash and went into the bathroom and washed her hands. NA C removed her gloves and placed them in the trash and washed her hands in the bathroom. NA C gathered the trash and exited the room to dispose of the trash. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/2024 at 9:23 AM, NA C said she had been employed at the facility since November 2023 and worked 6am-6pm. She stated during the care provided to Resident #15, she would not have done anything differently. She said she had a skills check-off with the DON yesterday 9/2/2024. She said she was trained on glove changes and if cream was applied to change gloves after that. She said she was taught to change periodically and to wash hands between gloves changes. She said if she was messing with the same person, then she would wash her hands before care was started and the only time, she would wash her hands between times was if she was dealing with fecal material. She said she probably should have washed or sanitized her hands during gloves changes. She said residents could be at risk for infections if staff do not wash or sanitize their hands. Record review of a competency skills check off dated 8/1/2024 for NA C reflected she was successful with incontinent care of a female resident. During an interview on 9/4/2024 at 11:49 AM, the DON who said hand hygiene should be performed before care was started and at any point gloves were changed and they were not to touch anything with dirty gloves. She said she was not aware of the incident with NA C with incontinent care on 9/3/2024. She said NA C had completed the CNA training program at their facility but had not scheduled to take her test. She said there was a risk for cross contamination, passing germs or infections if staff did not perform hand hygiene. During an interview on 9/5/2024 at 9:20 AM, the Administrator who said hand hygiene should be performed multiple times during care provided, when hands were visibly dirty, if going from one person to another, prior to any kind of care and after, between glove changes and if gloves were ripped or torn. She said residents could be at risk for infections if staff did not perform hand hygiene. Record review of a facility policy titled Handwashing/Hand Hygiene revised October 2023 reflected, .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Indications for Hand Hygiene: 1. Hand hygiene is indicated: g. Immediately after glove removal .