STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455876	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Healthcare Center	4650 S Panther Creek Drive The Woodlands, TX 77381

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 12 (Resident #1) reviewed for abuse. - The facility failed to report to the State Survey Agency a suspicious injury of unknown origin suffered when Resident #1 was found on the floor of his room on 07/29/25 with a deep 10 cm (3.9 inch) laceration (a tear or cut in skin and other tissues that causes bleeding) to the top of his head that required hospitalization and 15 staples. This failure could result in the state agency being unaware of alleged incidents of injury of unknown origin. Findings included: Record review of the HHSC TULIP (system to which providers report accidents and incidents) on 09/04/25 revealed, facility staff did not submit a submit a report of Resident #1's suspicious injury of unknown origin (deep 10 cm) laceration to the top of his head that required hospitalization and 15 staples.Record review of Resident #1's Face Sheet dated 08/26/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: heart failure, dementia, depression, high cholesterol, acid reflux, arthritis, abnormality in gait (how a person walks) and mobility and repeated falls. Record review of Resident #1's Quarterly MDS dated [DATE] revealed, minimal difficulty hearing, clear speech, moderately impaired cognition as indicated by a BIMS score of 10 out of 15, no upper or lower extremity functional limitation in range of motion and the use of a walker. Resident #1 required setup or clean-up assistance with putting on/taking off footwear and was independent for: roll left to right; moving from sitting to lying; moving from lying to sitting; sit to stand; chair/bed-to-chair transfer; toilet transfer; and the ability to walk 150 feet in a corridor or similar space. Resident #1 had 1 fall since the prior assessment that resulted in minor injuries.Record review of Resident #1's undated Care Plan revealed, Focus: ADL self-care performance deficit r/t Impaired balance, impulse control, and desired Independence, Resident #1 does not like to ask for assistance; Intervention: Resident uses rollator for ambulation independently and does not like to request assistance when ambulating or transfers, Res uses rollator for ambulation independently and does not like to request assistance when ambulating or transfers, The resident requires supervision by (1) staff to move between surfaces. Focus: he resident is High risk for falls r/t Gait/balance problems; Goal: The resident will not sustain serious injury through the review date; Intervention: Ensure that The resident is wearing appropriate footwear when ambulating or mobilizing in w/c. Focus: The resident is High risk for falls r/t Gait/balance problems, 5/29/2023: Fall with laceration to Left side of head, transferred to hospital returned with seven sutures to area, 1/07/25 while trying to charge hearing aids - no injury, 1/15/25 fall- no injury noted, Goal: The resident will resume usual activities without further incident; Interventions: 1/15/25 fall educated resident to call for assistance, therapy to screen, 1/7/25- attempted to relocate hearing aids near resident refused and wants items to stay where they are. Nursing staff are to anticipate needs with hearing aid care, 11/12/24: Fall with minor injury (abrasion to right knee)- educate resident on using call light for assistance.Record review of Resident #1's Change of Condition Communication Form dated 07/29/25 at 11:18 AM signed by LVN A revealed, on 07/29/25 the resident had a suspected fall with head laceration & uncontrolled bleeding.Record review of Resident #1's Fall Risk Evaluation dated 07/29/25 at 11:42 AM revealed, low fall risk as indicated by a score of 03.Record review of Resident #1's Provider Progress Note dated 07/29/25 revealed, fall with head laceration. He is being seen today for management of multiple medical issues including fall with head laceration. Patient is found lying on the floor in his room with a head laceration to his scalp that is bleeding. Staff applied pressure for the bleeding and another staff called 911. Patient was lying in his back when assessed and was talking and answering questions. Staff advised not to pick up the patient from the ground as EMS needs to assess him and apply neck brace due to the fall. A dressing was applied to the scalp laceration to keep the area clean as the bleeding had improved. Patient being sent to the hospital for evaluation and treatment and staples will be needed for the head laceration. Fall was unwitnessed as stated by staff. He is not on any blood thinners. He does not think he lost consciousness. Review of Systems- Neurological: no loss of consciousness; skin: laceration to the scalp