

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER The Woodlands Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4650 S Panther Creek Dr 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that pain management was provided to a resident who required such services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 15 residents (Resident #1) reviewed for pain management. The facility failed to administer Resident #1's scheduled pain medications on 05/29/2026 at 4:00pm Resident #1 did not receive Baclofen 5 mg, one tablet by mouth three times daily; Tramadol 50 mg, two tablets by mouth three times daily; and Zanaflex 6 mg, one capsule by mouth three times daily, as scheduled. This failure could place the resident at risk for increased pain, delayed treatment and pain management interventions. Findings included: Record review of Resident #1's Face Sheet, dated 10/02/2025, revealed a [AGE] year-old male, admitted on [DATE]. Record review of Resident #1's Quarterly MDS assessment, dated 04/02/2026, revealed a BIMS score of 15, indicating that he was cognitively intact. Section GG functional ability documented the resident required setup or clean-up assistance for eating. The resident was coded as requiring supervision or touching assistance for oral hygiene, upper body dressing, putting on and taking off footwear, personal hygiene, rolling left to right, sit-to-lying, lying-to-sitting on the side of the bed, sit-to-stand, chair/bed-to-chair transfers, wheeling 50 feet with two turns, and wheeling 150 feet. The resident was coded as requiring partial/moderate assistance for toilet transfers, tub/shower transfers, toileting hygiene, showering/bathing, and lower body dressing. Record review of Resident #1's care plan, revised on 04/20/2026, revealed: Problem: Category: Pain and non-participatory in plan of care for medication. Goal: No adverse outcomes. Approach: Educate resident on the risks and benefits of taking medications as prescribed. Record review of Resident #1's Medication Administration Audit Report, dated 06/04/2026, revealed that Resident #1 did not receive his Tramadol 50 mg, Baclofen 5 mg, and Zanaflex 6 mg at the scheduled administration time of 4:00 p.m. on 05/29/2026. During an interview with LVN-B on 06/04/2026 at 10:00 a.m., she stated that she did not administer Resident #1's medications because he was difficult to locate. She stated that she did not administer Resident #1's scheduled 4:00 p.m. medications on 05/29/2026, which included Tramadol 50 mg, Baclofen 5 mg, and Zanaflex 6 mg. She further stated that she did not notify the charge nurse or the Director of Nursing (DON). During an interview with the physician (MD) on 06/04/2026 at 11:00 a.m., she stated that LVN-B should have notified her that Resident #1 did not receive his scheduled medications at 4:00 p.m. on 05/29/2026. She stated that notification was necessary to inform her why the medications were not administered. The physician further stated that one missed dose of Resident #1's medications would not likely result in adverse effects and that the medications could be resumed at the next scheduled administration time. During an interview with the DON on 06/04/2026 at 11:30 a.m., she stated that she was not notified that Resident #1 did not receive his scheduled medications at 4:00 p.m. on 05/29/2026. She stated that the process for missed medications was for the LVN-B to notify the charge nurse, who then notified the ADON, who in turn notified the DON. She further stated that one missed dose would not likely result in an adverse reaction. During an interview with the ADON on 06/04/2026 at 11:50 a.m., she stated that she was not notified that Resident #1 did not receive his (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled medications at 4:00 p.m. on 05/29/2026. She stated that the process for missed medications was for the nurse to notify the charge nurse, who then notified the ADON, who in turn notified the DON. She further stated that one missed dose would not likely result in an adverse reaction. During an interview with Resident #1 on 06/04/2026 at 2:33 p.m., he stated that he did not receive his 4:00 p.m. medications on 05/29/2026. He stated that he was not experiencing severe pain and that he later requested his medications at approximately 7:30 p.m.; however, the nurse informed him that he could not receive them because he was scheduled to receive medications again at 8:00 p.m. During an interview with the Administrator on 06/04/2026 at 3:15 p.m., he stated that he was not notified that Resident #1 did not receive his medications on 05/29/2026 at 4:00 p.m. He stated that when a resident's medication was not administered, the ADON, DON, physician, and Administrator should be notified. He further stated that Resident #1 was capable of informing staff if he was experiencing pain and needed his medications. Record review of the facility's Pain Management Policy, dated 10/19/2019, stated, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.		