

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 12/19/2025
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, was provided such care, consistent with professional standards of practice for 3 (Residents #185, #55 and #49) of 5 reviewed for respiratory care. 1. Resident #185's Bi-pap (bilevel positive airway pressure) mask was not covered in a plastic bag when it was not used on 12/16/2025.2. The facility failed to ensure empty portable oxygen tank in Resident #55's room was secure and in a base.3.The facility failed to ensure Resident #49's received 2 liters of oxygen as ordered. This failure could affect residents with oxygen therapy and bilevel positive airway pressure and could lead them to lack of care including possible infection by not following infection control.1. Record review of Resident #185's face sheet, dated 12/19/2025, revealed the resident was a [AGE] year-old male and originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of cellulitis of left lower limb (skin infection to left leg), type 2 diabetes mellitus (not control blood sugars in the body), hypertension (high blood pressure), sleep apnea (when breathing stops and restarts many times while sleeping), and muscle wasting and atrophy (loss of skeletal muscle mass). Record review of Resident #185's admission MDS assessment was In progress because the resident was admitted to the facility on [DATE]. Record review of Resident #185's physician order, dated 12/02/2025, revealed the resident had the order of Apply BIPAP (bilevel positive airway pressure) at 14 IPAP (inspiratory positive airway pressure) / 10 EPAP (expiratory positive airway pressure), every time at bedtime. Observation on 12/16/2025 at 12:11 p.m. revealed Resident #185 was on the bed and talking to his wife at the bedside in his room. Resident #185's Bi-pap (bilevel positive airway pressure) mask connected to a machine was on the nightstand uncovered. During an interview on 12/16/2025 at 12:56 p.m. LVN-B stated Resident #185's Bi-pap (bilevel positive airway pressure) mask was on the nightstand without a plastic bag. Further interview with LVN-B said the resident's Bi-pap (bilevel positive airway pressure) mask should have been covered in a plastic bag when it was not used to prevent possible infection. During an interview on 12/19/2025 at 12:09 p.m. DON stated Resident #185's Bi-pap (bilevel positive airway pressure) mask should have been covered in a plastic bag when it was not used to prevent possible infections. DON said the facility did not have a policy related to specifically covering a mask in a plastic bag when not used, the facility follows standards nursing care, and it was nurse's responsibility. Record review of professional guidelines, titled World Health Organization - Care, cleaning and (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disinfection of Bi-pap devices (<a 204="" 55="" 942="" 968"="" data-label="Page-Footer" href="https://chrome-extension://efaidnbnmnibpcajpcglclefindmkaj/https://www.who.int/docs/default-source/coronaviruse/cdated 12/22/2025, revealed Ensure cleaned BiPAP/CPAP device is stored in an area where there is low risk of contamination between uses.</p> <p>2. Record review of Resident #55's face sheet, dated 12/18/2025, revealed Resident #55 was admitted on [DATE] with diagnoses which included: chronic obstructive pulmonary disease, unspecified and chronic respiratory failure with hypoxia.</p> <p>Record review of Resident #55's Quarterly MDS assessment, dated 09/16/2025, revealed the residents' BIMS score was 12 indicating moderate cognitive impairment. Section O indicated oxygen therapy was provided while a resident.</p> <p>Record review of Resident #55's care plan, target date 02/17/2026, revealed Resident #55 had a focus of The resident has altered respiratory status r/t COPD with an intervention of Oxygen at 2L LPM via nasal cannula PRN.</p> <p>Observation and interview on 12/16/2025 at 12:50 PM Resident #55 was observed sitting on her bed with a portable oxygen tank on the back of her wheelchair, a portable oxygen tank in a stand beside the bed and a portable oxygen tank sitting on the floor by the wall of her room. Resident #55 stated the staff had changed her oxygen tank on the back of her wheelchair yesterday and left the empty oxygen tank. Resident #55 stated she wore her oxygen when she got winded and tired but did not wear it all the time.</p> <p>During an interview on 12/16/2025 at 1:08 PM CNA G stated Resident #55 always had her oxygen on and further stated she did not work with the oxygen tanks. CNA G stated the nurse was responsible for the oxygen tanks.</p> <p>Observation and interview 12/16/2025 on 1:12 PM RN I stated someone probably changed Resident #55's oxygen tank and left it. RN I stated it was not safe for the tank not to be in a base and further stated the tank could fall. RN I stated the portable oxygen tank should have been sitting in a base. RN I stated when an oxygen tank was empty it was supposed to be removed from the room. RN I further stated the oxygen tank should be sitting in a base for safety precautions of the residents and the staff. The RN I stated emptied oxygen tanks were separated from the full oxygen tanks and kept secured in the oxygen room. RN I removed the oxygen tank from the floor or Resident #55's room.</p> <p>During an interview on 12/19/2025 at 10:36 AM the DON stated if the oxygen tanks were empty, they should have been returned to the storage room. The DON further stated oxygen tanks should be used in transport or when residents were out of the room. The DON stated portable oxygen tanks should be kept in a stand or wheelchair caddy if in the room and should not be sitting on the floor. The DON stated there was an explosive risk if the oxygen tanks were to fall over and the residents could trip over the tanks.</p> <p>During an interview on 12/19/2025 at 10:54 AM the Administrator stated there was a potential hazard by the oxygen tank sitting on the floor. The Administrator further stated if the oxygen tank was not on a wheelchair or was not in use should not be stored in the room. The Administrator stated the oxygen tank should have been in the holder or the carrier.</p> <p>3.
(continued on next page)</p> </td> </tr> </table> </div> <div data-bbox="> FORM CMS-2567 (02/99) Previous Versions Obsolete 		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's face sheet, dated 12/18/2025, revealed she was admitted on [DATE] with diagnoses which included: chronic obstructive pulmonary disease, unspecified, simple chronic bronchitis and other disorders of lung. Record review of Resident #49's Quarterly MDS assessment, dated 09/06/2025, revealed the resident's BIMS score was 13, indicating intact cognition. Record review of Resident #49's O2 Sats Summary dated 12/18/2025, revealed Resident #49 with oxygen values taken and receiving oxygen via nasal canula. Record review of Resident #49's Physician Order Summary, dated 12/16/2025, read, Oxygen administration at 2L/minutes via nasal canula as needed for SOB related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, start date 09/10/2025. Record review of Resident #49's care plan, with a revision date of 11/11/2025, revealed there was not a care plan reflecting Resident #49's use or need of oxygen. During an observation and interview on 12/17/2025 at 9:02 AM Resident #49 was observed sleeping in bed wearing her oxygen with oxygen concentrator set to 3 liters. LVN H stated Resident #49 has an order for 2 liters oxygen as needed, however, Resident #49 would adjust the liters sometimes. LVN H entered Resident #49's room and adjusted the oxygen concentrator. LVN H stated as he left the room that the oxygen concentrator was set at 3 liters and he adjusted it to 2 liters. Record review of facility's policy titled Oxygen Safety, implemented 01/26/2024, read Policy: It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. Policy explanation and Compliance Guidelines: 1. Safety is the responsibility of all staff, residents, visitors and the general public. 4. Oxygen Storage- c. Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full or empty.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 store all drugs and biologicals in locked compartments for 3 of 6 medication carts (med aide cart in hall 200, med aide cart in 300 hall, and med aide cart for secured hall) observed for medication storage. One unidentified small round white pill was observed in the bottom drawer of the medication cart on 200 hall. Medication aide cart on 200 hall was left unlocked and unattended in an out cove across from the nurses station. Two unidentified small round white pills were observed in the top drawer of the medication cart on 300 hall. One unidentified small round white pill was observed in the bottom drawer of the medication cart for the secured hall. This failure could place residents at risk of missing or misuse of drugs by unauthorized personnel. The findings were: Observation of medication aide cart on 300 hall on 12/18/2025 at 5:05 PM revealed one small round white pill and one small red tringle shaped pill in the bottom of a medication drawer. The pills were loose and not labeled with no identifying markers to indicate what it was. Medication cart was locked and secured. Observation of medication aide cart for the secured hall on 12/18/2025 at 5:11 PM revealed one small round white pill in the bottom of a medication drawer. The pill was loose and not labeled with no identifying markers to indicate what it was. Medication cart was locked and secured. Interview with ADON K on 12/18/2025 at 5:14 PM revealed the medication aide (MA) assigned to the medication carts for 300 hall and the secured unit was on break at the time of observations. ADON K stated all medications were to be stored in pill bottles or blister packs and if a pill was dropped it was to be disposed of per facility policy. ADON K stated it was the responsibility of the MA to ensure med carts were clean and all medications were stored in packaging and not loose in the medication cart. ADON stated there was no possible harm to the residents if a pill was loose in the medication cart because medication aides knew not to use loose pills and to dispose of them per facility policy. Observation of medication aide cart on 200 hall on 12/18/2025 at 5:32 PM revealed the medication cart was in the corner across the hall from the nurse's station unlocked and unattended. One small round white pill was observed in the bottom of a medication cart. The pill was loose and not labeled with no identifying markers to indicate what it was. Interview with MA L on 12/18/2025 at 5:33 PM revealed she was behind the nurse's station and her medication cart was within eyesight. MA L stated she was not using her medication cart at the time surveyor observed it unlocked. MA L stated she was not within reach of her medication cart but there were no residents within reach either. MA L stated it was the responsibility of each MA to ensure their medication carts were clean and free from loose pills. MA L was unable to identify how loose pills in the medication cart could have harmed residents. MA L stated residents could have got into the unlocked medication cart and taken meds that were not theirs. MA L stated if a loose pill was found in the medication cart it was to be disposed of according to the facility policy. Interview with MA M on 12/19/2025 at 11:40 AM revealed she was the medication aide assigned to the medication carts for 300 hall and the secured unit on 12/18/2025 when surveyor made observations. MA M stated medication aides were responsible for the cleaning of the carts and ensuring medications were stored per facility policy. MA M stated medications were to be stored in blister packs or medication bottles and labeled with resident's name. MA M stated if a pill was found loose in the cart it was to be disposed of. MA M was unable to identify how loose pills in the medication cart could have harmed residents. Interview with DON and Administrator on 12/19/2025 at 11:53 AM revealed medication aides were responsible to ensure medication carts were secured when not in use. DON stated medications were to be stored in labeled blister packs or bottles. DON stated if a loose pill was found it was to be disposed of. DON and Administrator stated it was the responsibility of the medication aide assigned to the cart to ensure it was clean, everything was stored properly and secured when not in use. DON and Administrator stated residents had the potential to take (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications that were not theirs if there was an unlocked medication carts and/or loose pills. Record review of facility policy named Medication Administration, dated 10/01/19, revealed 2. The medication cart is locked at all times when not in use. Policy regarding medication storage was requested from the ADON K on 12/18/2025 at 5:14 PM and requested from the Administrator and DON on 12/19/2025 at 11:53 AM but not provided prior to exit.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement.1. The facility failed to ensure leftovers to be used later with a temperature in the danger zone were discarded. 2. The facility failed to ensure food was stored 6 inches off the floor. These failures could place residents who ate food from the kitchen at risk of food- borne illness and disease. Observation of the facility kitchen on 12/16/25 at 8:45 AM revealed the following. 1. A pan of white gravy 45.7 degrees Fahrenheit with a temperature in the danger zone.2. A Plastic container of Scrambled eggs 55 degrees Fahrenheit.3. A Pan of hot dogs 50 degrees Fahrenheit with a temperature in the danger zone. 4. A case of canned chicken noodle soup stored on the floor in the storeroom. An interview with the Dietary Food Service Manager on 12/16/25 at 8:45 AM; revealed that the following foods were stored in the refrigerator and were to be used the following day. She stated the leftover food with danger zone temperatures of 40 degrees Fahrenheit to 140 degrees Fahrenheit should have been discarded. She further stated that she will in-service dietary staff on proper handling, storing, and dating leftover food for compliance .Record review of the facility's policies and procedures for Food Safety dated 2018 read in part .potentially hazardous leftover foods are properly covered, labeled, dated, and refrigerated immediately. They are discarded after 72 hours unless otherwise indicated. For		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 3 (Resident #187, #97, and #138) of 33 residents reviewed for infection control practices. 1. MA-F measured Resident #187's blood pressure without cleaning the blood pressure cuff on 12/17/2025. 2. When CNA-A and CNA-G were providing indwelling urinary catheter care to Resident #97, they did not wear gowns. Resident #97 had enhanced barrier precautions, and the sign attached on the door said, Staff must wear gloves and gown for the following high-contact resident care activities such as urinary catheter care. 3. Resident #138's oral suction Yankauer (the tool is used to suction to prevent aspiration) connected to the suction machine was on the floor on 12/16/2025 without covering it with a plastic bag. This deficient practice could place residents at risk for cross contamination and infections. The findings included: 1. Record review of Resident #187's face sheet, dated 12/19/2025, revealed the resident was an [AGE] year old male and admitted to the facility on [DATE] with diagnoses of heart failure (the heart can't pump enough oxygen-rich blood to meet your body's needs), hypertension (high blood pressures), muscle wasting and atrophy (loss of skeletal muscle mass), and atherosclerotic heart disease of native coronary artery (plaque and blood clots can reduce blood flow through an artery). Record review of Resident #187's admission MDS assessment was in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #187's physician order, dated 12/15/2025, revealed Midodrine Oral Tablet 2.5 milligram - Give 1 tablet by mouth three times a day for hypertension Hold if systolic blood pressure greater than 130. [sic] Observation on 12/17/2025 at 4:20 p.m. revealed MA-F came out from another resident's room with a blood pressure cuff and machine. Further observation on 12/17/2025 at 4:38 p.m. revealed MA-F opened the computer and entered Resident #187's room and measured the resident's blood pressure without cleaning the blood pressure cuff and machine. During an interview on 12/17/2025 at 4:47 p.m. with MA-F stated she measured Resident #187's blood pressure without cleaning the blood pressure cuff and machine that she already used to another resident. The MA-F said she should have cleaned the blood pressure cuff and machine before measuring Resident #187's blood pressure to prevent possible infection, and it was her mistake. 2. Record review of Resident #97's face sheet, dated 12/19/2025, revealed the resident was a [AGE] year old female, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heartbeat), hypokalemia (low potassium level in the blood), muscle wasting and atrophy (loss of skeletal muscle mass), acute kidney failure (kidney lose the ability to remove waste and balance fluids), and heart failure (the heart muscle does not pump blood as well as it should). Record review of Resident #97's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 12 out of 15 which indicated the resident had moderate cognitive impairment and had indwelling urinary catheter. Record review of Resident #97's comprehensive care plan, dated 04/24/2025, revealed Resident has the need for Enhanced Barrier Precautions due to indwelling urinary catheter. For intervention - Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high- contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shield as indicated. Observation on 12/18/2025 at 2:06 p.m. revealed CNA-A and CNA-G were providing indwelling urinary catheter care including perineal care to Resident #97 and put on gloves, but they did not wear gowns for entire procedures. Further observation on 12/18/2025 at 2:10 p.m. revealed there was Enhanced Barrier Precautions sign and personal protective equipment such as gloves and gowns placed on the door. During an interview on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/18/2025 at 2:14 p.m. with CNA-A and CNA-G stated they did not wear gowns because they forgot. The CNA-A and CNA-G said they should have put on gowns when providing indwelling urinary catheter care to Resident #97 because the resident had Enhanced Barrier Precautions, and catheter care was one of high- contact resident care activities to prevent possible infection. During an interview on 12/18/2025 at 3:44 p.m. with DON said CNA-A and CNA-G should have put on gowns when providing indwelling urinary catheter care to Resident #97 because the resident had Enhanced Barrier Precautions, and catheter care was one of high- contact resident care activities to prevent possible infection. 3. Record review of Resident #138's face sheet, dated 12/19/2025, revealed the resident was a [AGE] year old female and admitted to the facility on [DATE] with diagnoses of acute respiratory failure (severe shortness of breath), local infection of the skin, cerebral infarction (brain tissue death due to the blood vessel blockage), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #138's admission MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to bed mobility and Substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to sit to stand and chair to bed transfer. Record review of Resident #138's comprehensive care plan, dated 12/02/2025, revealed Impaired breathing mechanics, decannulated, requires suctioning orally at times. The resident prefers to suction herself. For intervention - The resident has demonstrated that she can self-orally suction herself and chooses to do so. Replace Yankauer as needed. Clean suction machine per facility protocol. Observation on 12/16/2025 at 11:22 a.m. revealed Resident #138 was on the bed in her room, there was an oral suction machine on the nightstand at the bedside, and the oral suction Yankauer (the tool is used to suction to prevent aspiration) connected to the suction machine was on the floor without covering it with a plastic bag. During an interview on 12/16/2025 at 1:04 p.m. with RN-J stated Resident #138's oral suction Yankauer connected to the suction machine was on the floor without covering it with a plastic bag. RN-J said the resident could suction by herself with the Yankauer, but the facility should have covered the Yankauer with a plastic bag when it was not used to prevent infection. During an interview on 12/19/2025 at 12:09 p.m. the DON said the facility nurses should have covered Resident #138's oral suction Yankauer with a plastic bag when it was not used to prevent infection. Record review of the facility policy, titled Infection prevention and control program, dated on 05/13/2023, revealed . 10. Equipment protocol - All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Reusable items potentially contaminated with infectious materials shall be placed on an impervious clean plastic bag. Record review of the facility policy, titled Enhanced barrier precautions, dated 11/24/2025, revealed Employees targeted gown and gloves use during high contact resident care activities - High-contact resident care activities include: device care or use such as urinary catheter.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 2 of 17 residents (Resident #151 and #140) reviewed for resident rights. CNA-A and LVN-B were standing over Residents #151 and #140 while assisting them to eat, rather than sitting next to the residents, on 12/16/2025 at the dining area of the memory care unit. This failure could place residents at risk for decreased quality of life, quality of care, and self-esteem. Findings included: Record review of Resident #151's face sheet, dated 12/19/2025, revealed the resident was a [AGE] year old female and admitted to the facility on [DATE] with diagnoses of senile degeneration of brain (progressive decline in cognitive function), dementia (loss of memory and thinking ability), and Alzheimer's disease (progressive disease that destroy memories and other important mental functions). Record review of Resident #151's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment and required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating. Record review of Resident #151's comprehensive care plan, dated 04/29/2025, revealed The resident is limited assist with one person for meals. Record review Resident #140's face sheet, dated 12/19/2025, revealed the resident was a [AGE] year old female and admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (progressive disease that destroy memories and other important mental functions), dementia (loss of memory and thinking ability), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #140's annual MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment and required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating. Record review of Resident #140's comprehensive care plan, dated 10/29/2025, revealed The resident requires set up and clean up assistance with one staff to eat. Observation on 12/16/2025 at 12:27 p.m. at the dining area of the facility memory care unit revealed Residents #151 and #140 sat next to each other, CNA-A in front of the residents was standing over Resident #151 and #140 while assisting and sometimes feeding them to eat. Further observation on 12/16/2025 at 12:30 p.m. revealed that LVN-B was also standing over Residents #151 and #140 while assisting them to eat, rather than sitting next to the residents, and CNA-A was helping other residents. During an interview on 12/16/2025 at 12:45 p.m. CNA-A and LVN-B stated they were standing over Residents #151 and #140 while assisting them to eat, rather than sitting next to the residents because they were busy helping residents in the memory care unit. CNA-A and LVN-B said they should have sat next to Residents #151 and #140 while helping them to eat to give respect and dignity. During an interview on 12/19/2025 at 12:09 p.m. with DON said that the facility staff should have sat next to Residents #151 and #140 while helping them to eat to give respect and dignity, and all staff were trained on resident rights. Record review of the facility policy, titled promoting and maintaining resident dignity, dated 01/13/2023, revealed 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.		

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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	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 33 residents (Resident #166) reviewed for assessments: Resident #166's quarterly MDS, dated [DATE], identified the resident was receiving hospice care. However, Resident #166's Prognosis of Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? was coded to No, instead of Yes in Section J (health Conditions). This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #166's face sheet, dated 12/19/2025, revealed the resident was an [AGE] year old female, originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses of fracture of unspecified part of neck, chronic kidney disease (kidneys have become damaged over time and have a hard time doing all their important jobs), atrial fibrillation (irregular and often very rapid heart rhythm), and dementia (over time destroy nerve cells and damage the brain). Record review of Resident #166's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 4 out of 15, which indicated the resident had severe cognitive impairment, and in Section O (Special Treatment, Procedures, and Program), the resident was receiving hospice care. However, in Section J (health Conditions), Prognosis of Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? was coded to No, instead of Yes. Record review of Resident #166's comprehensive care plan, dated 11/24/2025, revealed that The resident is currently under the care of Hospice Services. Record review of Resident #166's certification of terminal illness, dated 11/29/25, revealed the resident's physician certified the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months. During an interview on 12/19/2025 at 10:30 a.m. MDS nurse RN-C stated Resident #166's quarterly MDS, dated [DATE], indicated the resident was receiving hospice care. However, Resident #166's Prognosis of Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? was coded to No, instead of Yes in Section J (health Conditions). The MDS RN-C said that it was a mistake, and it should have been coded No because Resident #166 was receiving hospice services. MDS RN-C said coding accurately was a MDS nurse's responsibility, and inaccurate MDS assessments might result in improper care to the resident, and the facility did not have policy for MDS accuracy, but following CMS's RAI Manual guidelines. Record review of CMS's RAI version 3.0 Manual, titled J1400: Prognosis, paged J-29, dated 10/2025, revealed Coding instructions - Code Yes if the resident is receiving hospice services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #49) reviewed for care plans. The facility failed to ensure Resident #49's care plan included her need for oxygen as needed. This deficient practice placed residents at risk of not receiving proper care and services. The findings were: Record review of Resident #49's face sheet, dated 12/18/2025, revealed she was admitted on [DATE] with diagnoses which included: chronic obstructive pulmonary disease, unspecified, simple chronic bronchitis and other disorders of lung. Record review of Resident #49's Quarterly MDS assessment, dated 09/06/2025, revealed the resident's BIMS score was 13, indicating intact cognition. Record review of Resident #49's O2 Sats Summary dated 12/18/2025, revealed Resident #49 with oxygen values taken and receiving oxygen via nasal canula from 10/18/2025 to 12/18/2025. Record review of Resident #49's Physician Order Summary, dated 12/16/2025, read, Oxygen administration at 2L/minutes via nasal canula as needed for SOB related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, start date 09/10/2025. Record review of Resident #49's care plan, with a revision date of 11/11/2025, revealed there was not a care plan reflecting Resident #49's use or need of oxygen. During an observation and interview on 12/17/2025 at 9:02 AM Resident #49 was observed sleeping in bed wearing her oxygen with oxygen concentrator set to 3 liters. LVN H stated Resident #49 has an order for 2 liters oxygen as needed, however, Resident #49 would adjust the liters sometimes. LVN H entered Resident #49's room and adjusted the oxygen concentrator. LVN H stated as he left the room that the oxygen concentrator was set at 3 liters and he adjusted it to 2 liters. During an observation and interview on 12/19/2025 at 10:13 AM MDS RN C was observed reviewing Resident #49's care plan and stated she did not see the oxygen use addressed in Resident #49's care plan. MDS RN C further stated oxygen use would have been something that would have been care planned. MDS RN C stated she looked at the orders and it looked like the oxygen use started 09/10/2025 and she was not sure why it was started back then. MDS RN C stated care plans were to address the needs of residents, the need for monitoring, how to monitor, and the care needed by the residents. MDS RN C further stated by not care planning needs of residents could put the residents at risk of deteriorating and staff would not know how they should care for them. During an interview on 12/19/2025 at 10:27 AM the DON stated nursing should have care planned Resident #49's use of oxygen. Then DON stated the MDS RN would have addressed it when submitting an MDS because they should have reviewed the MDS. The DON stated nursing was responsible for care planning acute issues and changes with a resident. The DON stated the care plan was the communication of the care of the residents, and it pulled to the Kardex (physical or digital summary of patient care details) for the staff to know the care to be provided. The DON stated if needs had not been care planned the staff might not have known the interventions needed. The DON stated it was also important to have care planned Resident #49's behavior of adjusting the oxygen concentrator, due to it would be important so staff would know to check to make sure it was on the ordered setting. Record review of facility's Comprehensive Care Plans policy, revision date, 10/24/2022 read, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 3. The comprehensive care plan will describe, at a minimum, the following: a. The services (continued on next page)		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #22) reviewed for incontinence care. When CNA-D was providing perineal care to Resident #22 on 12/18/2025, CNA-D did not clean the resident's right and left buttock area. These failures could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: Record review of Resident #22's face sheet, dated 12/19/2025, revealed Resident #22 was a [AGE] year old female, admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with the diagnoses of acute kidney failure (kidney lose the ability to remove waste and balance fluids), hyperkalemia (high potassium level in the blood), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and elevated white blood cell count (high white blood cell in the blood, including infection). Record review of Resident #22's annual MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment, and the resident was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to toilet hygiene, sit to stand, and chair to bed transfer. Further record review of the MDS indicated Resident #22 was frequently bladder and bowel incontinent. Record review of Resident #22's comprehensive care plan, dated 01/31/2024, revealed the resident had the care plan of The resident has MIXED bladder incontinence and bowel incontinence related to Dementia, Impaired Mobility. For intervention - Clean peri-area with each incontinence episode. Observation on 12/18/2025 at 9:21 a.m. revealed CNA-D washed her hands with water, put on gloves and gown, opened the old and dirty brief of Resident #22, then cleaned the resident's genital area by separating labia and cleaned left and right groin area. Then CNA-D turned Resident #22 on her side and cleaned the resident's anal area. CNA-D did not clean the resident's left and right buttock area. Further observation revealed CNA-D changed her gloves after sanitizing her hands and put a new and clean brief under the resident, then closed the brief. During an interview on 12/18/2025 at 9:27 a.m. CNA-D acknowledged she did not clean Resident #22's left and right buttock areas. CNA-D said she was very nervous, so she forgot cleaning Resident #22's left and right buttock areas. CNA-D stated she should have cleaned those areas to prevent possible infection. During an interview on 12/18/2025 at 3:42 p.m. DON stated CNA-D should have cleaned Resident #22's left and right buttock areas to prevent possible infection and skin breakdown. Record review of the facility policy, titled Perineal Care, revised 12/2020, dated 10/24/2022, revealed It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection the extent possible and top prevent and assess for skin breakdown.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #86) out of 8 residents reviewed for medical records. Resident #86's electronic medication administration record was inaccurate as evidence by indicating Rosuvastatin Calcium Tablet 20 milligram, give 1 tablet via gastrostomy tube one time a day for lipid control, but the physician order said Rosuvastatin Calcium Tablet 40 milligram. This failure placed residents at risk for missed treatment and medications which could result in decline in health and well-being. Findings included: Record review of Resident #86's face sheet, dated 12/19/2025, revealed the resident was an [AGE] year old male, originally admitted on [DATE], and re-admitted to the facility on [DATE] with diagnoses of syncope and collapse (passing out), acute kidney failure (kidney lose the ability to remove waste and balance fluids), muscle wasting and atrophy (loss of skeletal muscle mass), and atherosclerotic heart disease of native coronary artery (plaque and blood clots can reduce blood flow through an artery). Record review of Resident #86's admission MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to most activities of daily life such as sit to stand, chair-to-bed, and toilet transfer and had gastrostomy tube. Record review of Resident #86's physician order, dated 11/15/2025, revealed the resident had the order of Rosuvastatin Calcium Tablet 40 milligram, Give 1 tablet via gastrostomy tube one time a day for lipid control. Record review of Resident #86's electronic medication administration record from 12/01/2025 to 12/31/2025 revealed Rosuvastatin Calcium Tablet 20 milligram Give 1 tablet via gastrostomy tube one time a day for lipid control - Start Date - 11/15/2025. Observation on 12/17/2025 at 8:29 a.m. revealed RN-E administered Rosuvastatin Calcium Tablet 40 milligram one tablet to Resident #86 via gastrostomy tube. During an interview on 12/17/2025 at 8:30 a.m. RN-E said Resident #86's primary care physician gave the order of Rosuvastatin Calcium Tablet 40 milligram, but the electronic medication administration record indicated Rosuvastatin Calcium Tablet 20 milligram. Further interview with RN-E stated she did not know what reason Resident #86's electronic medication administration record was inaccurate, but she thought the facility nurse might have made a mistake when entering this medication to the electronic medical record system when the resident returned to the facility on [DATE] from the acute hospital. During an interview on 12/18/2025 at 3:48 p.m. the DON stated Resident #86's electronic medication administration record was incorrect because the resident's primary care physician order indicated Rosuvastatin Calcium Tablet 40 milligram, Give 1 tablet via gastrostomy tube one time a day for lipid control. The DON said the resident's electronic medication administration record should have been accurate to prevent providing incorrect dosage to the resident, and it was the facility nurses' mistake. The DON had responsibility to oversee residents had accurate medication administration records. Record review of the facility policy, titled Medication Reconciliation, dated 04/10/2023, revealed the process of verifying that the resident's current medication list matches the physician's orders for the purpose of providing the correct medications to the resident at all points throughout his or her stay.		