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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675001 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/13/2025 |
| NAME OF PROVIDER OR SUPPLIER The Woodlands | | STREET ADDRESS, CITY, STATE, ZIP CODE 125 Inspiration Blvd Eastland, TX 76448 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care plan and provide a summary of their baseline care plan to residents for 1 (Resident #44) of 5 residents reviewed for baseline care plan completion. The facility failed to complete Resident #44's baseline care plan within the required 48-hour timeframe. This failure could place residents who were newly admitted at risk for not receiving necessary care and services or having important care needs identified. Findings included: Record review of Resident #44's face sheet dated 08/12/2025 revealed a [AGE] year-old female admitted on [DATE] with the following diagnoses fracture of femur, high blood pressure, atrial fibrillation (abnormal heart rhythm) and muscle weakness. Record review of Resident #44's admission MDS dated [DATE] revealed in Section C - Cognitive Patterns revealed a BIMS score of 15 (cognitively intact). Record review of Resident #44's electronic medical record revealed Resident #44's baseline care plan was initiated on 08/13/2025. During an observation and interview on 08/12/2025 at 11:35 AM Resident #44 was sitting in her room in her wheelchair. Resident #44 stated she was at facility for breaking her hip. During an interview on 08/13/2025 at 11:07 AM the RNC stated her expectation was that baseline care plans should have been completed within 48 hours of admission. The RNC stated she had initiated the baseline care plan for Resident #44 today. The RNC stated that the baseline care plan had not been completed in the required 48 hours. The RNC stated the charge nurse, and the DON were responsible for completing the baseline care plan. The RNC did not provide a reason for what led to failure. During an interview on 08/13/2025 at 2:15 PM the DON stated her expectation was baseline care plans should have been completed within the 48 hours of admission. The DON stated the charge nurse was responsible for initiating the baseline care plan. The DON stated what led to failure was oversight by staff. During an interview on 08/13/2025 at 3:30 PM the ADMN stated her expectation was baseline care plans should have been completed within 48 hours of admission. The ADMN stated the charge nurse was responsible for completing the baseline care plan. The ADMN stated the DON was responsible for monitoring to ensure the baseline care plans were completed within 48 hours. The ADMN stated she did not think there was a negative effect on resident not having baseline care completed. The ADMN did not give a reason for the failure of Resident #44's baseline care plan completed. Record review of the facility policy titled, Care Plans-Baseline dated March 2022, revealed A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p> |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**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 time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 2 residents (Resident #2, and Resident #6) reviewed for care plans in that: Resident #2 did not have a comprehensive care plan in place that included a code status of do not resuscitate. Resident #6 did not have a comprehensive care plan in place that included use of a trapeze (equipment attached to a resident's bed to aide in independent repositioning). This failure could affect residents by placing them at risk of not receiving individualized care and services to achieve their goals. The findings included the following: Review of Resident #2's Resident Face Sheet dated [DATE], revealed he was an [AGE] year-old male initially admitted to the facility on [DATE] and had a most recent admission date of [DATE] with medical diagnoses including pancreatic cancer, pressure ulcer on sacrum (lower part of the back), shortness of breath, low thyroid function, depression, anxiety, high blood pressure, macular degeneration, weakness, and bladder cancer. Under Other Information, DNR, Yes was entered. Review of Resident #2's Quarterly MDS Assessment, dated [DATE], Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed he had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Review of Resident #2's physician's order dated [DATE] revealed an order **Code Status: ***DNR***. Review of Resident #2's miscellaneous records revealed an Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) order signed by Resident #2's physician and notarized on [DATE]. Review of Resident #2's Comprehensive Care plan reviewed/ revised [DATE] revealed: Focus Resident and or RP/family have advance directive of choice to be FULL CODE status. Observation on [DATE] 8:28 AM Resident # 2 was in his bed sleeping. Resident #6 Review of Resident #6's Resident Face Sheet, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses including intracerebral hemorrhage (brain bleeding), urinary incontinence (inability to control urine output), dysphagia (problems with swallowing), anxiety, shortness of breath, depression, post-traumatic stress disorder, high blood pressure, myocardial infarction (heart attack), chronic kidney disease, and pain. Review of Resident #6's Quarterly MDS Assessment, dated [DATE], revealed he had a BIMS score of 09 out of 15, indicating moderate cognitive impairment. Review of Resident #6's physician orders dated [DATE] revealed Trapeze to be used for mobility. Review of Resident #6's Comprehensive Care Plan reviewed/ revised [DATE] revealed use of a trapeze was not addressed on the care plan. Observation on [DATE] at 10:08 AM, revealed a trapeze device to assist the resident with repositioning was attached to the headboard of Resident #6's bed. During an interview on [DATE] at 11:33 AM, LVN A stated she was not aware that Resident #6's trapeze was not on his care plan, she thought it was. She stated she did not think the resident would suffer adverse effects of the trapeze not being on the care plan. During an interview on [DATE] at 2:24 PM, with the DON and the RNC, the DON stated she was surprised Resident #6's trapeze was not on the care plan. She stated she could not explain why it was not. The DON stated her expectations were for care plans to be completed on time and accurate. She stated she could not think of an adverse effect on the resident if the trapeze was not addressed on the care plan. The RNC stated the CAAs provided the basis for care planning. She explained the facility conducts IDT meetings every weekday morning at which time acute events were identified and a decision made by the team to add to the care plan. She stated it was important to include everything on the care plan, so the staff were aware. The DON stated the ADON was responsible for reviewing/ revising care plans. The RNC stated the DON was ultimately responsible for the accuracy of the care plans. During an interview on [DATE] at 2:39 PM, the ADON stated she had been in the ADON position for 4 months. She explained training was provided on the job from the DON and corporate support. The ADON stated she did not initiate care plans but was responsible for keeping care plans up to date. She stated she did not know how the trapeze was missed on Resident #6's care plan. The ADON stated Resident #6 was the only resident with trapeze. She stated consequences to the resident of failing to include the trapeze on the care plan would be if staff was not aware he had a trapeze and he needed it. During an interview on [DATE] at 2:45 PM, the DON stated a DNR status should be care planned. She explained that could affect the resident who might receive CPR against their wishes. The DON stated she did not know what caused the failure to include Resident #2's code status on the care plan to occur. The DON stated that she and the MDS coordinator were responsible for monitoring the accuracy of the care</p> | | |

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| <p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on record review and interviews, the facility failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, seven days a week for 7 of 90 (02/02/2025, 02/15/2025, 02/16/2025, 03/01/2025, 03/02/2025, 03/15/2025 and 03/16/2025) days reviewed for RN coverage. The facility failed to provide evidence that a Registered Nurse (RN) worked 8 consecutive hours a day, seven days a week on 02/02/2025, 02/15/2025, 02/16/2025, 03/01/2025, 03/02/2025, 03/15/2025 and 03/16/2025. This failure placed the residents at risk for not having decisions made that would have required an RN to make in the management of the residents' healthcare needs and in managing and monitoring of the direct care staff. Findings included:Record review of the facility's Direct Care Staff Daily Report for Fiscal Year Quarter 2 (January 1, 2025, to March 31, 2025), revealed on 02/02/2025, 02/15/2025, 02/16/2025, 03/01/2025, 03/02/2025, 03/15/2025 and 03/16/2025 there was no evidence of 8 hour RN coverage. During an interview on 08/13/2025 at 2:15 PM the DON stated her expectation was to have RN coverage 8 hours a day. The DON stated the ADMN was responsible for making the staffing schedule. The DON stated she did not feel there was a negative impact to residents, because she was available by phone and lived close to the facility. The DON stated what led to failure was the inability to hire RN's. During an interview on 08/13/2025 at 3:30 PM the ADMN stated her expectation was to follow policy and have RN coverage 8 hours a day. The ADMN stated she was responsible for creating the staffing schedule. The ADMN stated she did not feel there was a negative effect on residents, due to the support staff available by phone. The ADMN stated what led to failure was the facility did not have a weekend RN during the months of February and March. The ADMN stated they had been trying to hire a RN during the time frame. The ADMN stated they did not have a policy for RN staffing.</p> | | |

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| F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (continued on next page) |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Based on observation, interview, and record review the facility failed to employ sufficient number of staff to carry out the functions of the food and nutrition service department for 1 of 1 kitchenThe facility failed to ensure there were sufficient number of staff who prepared meals in the kitchen and served cooked food to residents at posted mealtimes. This failure could place residents at risk of not having their nutritional needs met and delay assistance with activities of daily living. Findings included:During an observation on 08/11/2025 at 09:50 AM the resident mealtimes posted outside of the kitchen read: Breakfast 7:15 AM Memory Care7:45 AM Hall trays, 8:00 AM Main Dining Room.Lunch 11:15 AM Memory Care, 11:45 AM Hall trays, 12:00 PM Main Dining RoomDinner 4:15 PM Memory Care, 4:45 PM Hall Trays, 5:00 PM Main Dining RoomDuring an observation on 08/11/2025 at 09:51 AM revealed 1 DM, 1 [NAME] and 1 dishwasher in the kitchen preparing for lunch meal. During an observation on 08/11/2025 at 1:10 PM the hall trays for long term care residents were sent out of the kitchen. , one hour and 20 minutes past posted mealtime.During an observation on 08/11/2025 at 1:30 PM the meal was delivered to meal service area located in the main dining room.During an observation on 08/11/2025 at 2:05 PM meal service completed, and all residents had been served,. During an observation on 08/12/2025 at 08:28 AM revealed breakfast being served in the main dining room.During an observation on 08/13/2025 at 12:15 PM the hall trays were delivered to Hall 400. During an observation on 08/13/2025 at 12:27 PM meal arrived from the kitchen to service area in main dining room. , 27 minutes past posted mealtime. During an observation on 08/13/2025 at 12:42 PM first meal tray was delivered to first resident in the main dining room. , 42 minutes past pasted mealtime. During a group interview on 08/12/2025 at 11:00 AM 8 of 8 residents stated meals were not on time. The residents' stated meals were 1-2 hours late. The residents stated there was a sign by the menu that stated when meals were to be served. The residents stated the meals were never served at the time posted. The residents stated when lunch was late then activities, such as BINGO, were also late. During an interview on 08/13/2025 at 2:25 PM with the DM, she stated meal service was late due to being understaffed. She stated there should have been one cook, one dishwasher and 2 dietary aides for each meal. The DM stated meal service being late effects resident a great deal. The DM stated medications must be held or given later. The DM stated the residents were used to having meals at a certain time and being late with meals can affect their attitude and how much the residents would eat. The DM stated she was responsible for making sure meals were served on time. The DM stated the ADMN also monitored meal service.During an interview on 08/13/2025 at 2:45 PM the DON stated her expectations were that meals would be served on time per schedule. The DON stated meals being late affected the residents' medications and their activities of daily living activities, such as showers and incontinent care. During an interview on 08/13/2025 at 2:50 PM the ADMN stated her expectation was for meals to be served at the time posted. The ADMN stated meals were not being served on time due to a large turnover in kitchen staff. The ADMN stated meal service not being on time can affect the resident's medication routine and activities of daily living such as showers and incontinent care. The ADMN stated the residents had the expectation of meals being served on time. The ADMN stated meal service times were monitored by the department heads. The ADMIN stated she had been trying to hire more kitchen staff but had not had many qualified applicants. Record review of facility's grievance log dated April 2025, May 2025, June 2025 and July 2025 revealed residents filed a grievance concerning meals being late. Record review of facility's policy titled, Food and Nutrition Services not dated revealed: Policy statement: Each resident is provided with a nourishing palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preference of each resident.3. Meals and/or nutritional supplements will be provided within 45 minutes of either resident request or scheduled mealtime, and in accordance with the resident's medication requirements.9. Meals are scheduled at regular times to assure that each resident receives at least three (3) meals per day. Mealtimes are posted in facility common areas.</p> | | |

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| <p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Based on observation, interview, and record review the facility failed to employ sufficient staff to carry out the functions of the food and nutrition service department for 1 Of 1 kitchen. The facility failed to ensure that meals were served at the post mealtimes. This failure could place residents at risk of not having their nutritional needs met and delay assistance with activities of daily living. Findings included: During an observation on 08/11/2025 at 09:50 AM resident mealtimes posted outside of kitchen: Breakfast 7:15 AM Memory Care 7:45 AM Hall trays, 8:00 AM Main Dining Room. Lunch 11:15 AM Memory Care, 11:45 AM Hall trays, 12:00 PM Main Dining Room Dinner 4:15 PM Memory Care, 4:45 PM Hall Trays, 5:00 PM Main Dining Room During an observation on 08/11/2025 at 09:51 AM observed 1 DM, 1 [NAME] and 1 dishwasher in the kitchen preparing for lunch meal. During an observation on 08/11/2025 at 1:10 PM hall trays for long term care residents were sent out of the kitchen. During an observation on 08/11/2025 at 1:30 PM the meal was delivered to meal service area located in the main dining room. During an observation on 08/11/2025 at 2:05 PM meal service completed, and all residents had been served. During an observation on 08/12/2025 at 08:28 observed breakfast being served in main dining room. During an observation on 08/13/2025 at 12:15 PM hall trays were delivered to Hall 400. During an observation on 08/13/2025 at 12:27 PM meal arrived from the kitchen to service area in main dining room. During an observation on 08/13/2025 at 12:42 PM first meal tray was delivered to first resident in the main dining room. During a group interview on 08/12/2025 at 11:00 AM 8 of 8 residents stated meals are not on time. The residents' stated meals are 1-2 hours late. The residents stated there was a sign by the menu that states when meals are to be served. The residents' stated the meals are never served at the time posted. The resident's stated when lunch is late then activities such as BINGO was also late. During an interview with DM on 08/13/2025 at 2:25 PM stated meal service was late due to being understaffed. She stated there should have been one cook, one dishwasher and 2 dietary aides for each meal. DM stated meal service being late effects resident a great deal. DM stated medications must be held or given later. The DM stated the residents were used to having meals at a certain time and being late with meals can affect their attitude and how much the residents would eat. The DM stated that she was responsible for making sure that meals are served on time. DM stated the ADMN also monitors meal service. During an interview with DON on 08/13/2025 at 2:45 PM DON stated her expectations was that meals would be served on time per schedule. DON stated meals being late affect the residents' medications and activity of daily living activities such as showers, incontinent care. DON stated all residents eat meals from the kitchen. During an interview with ADMN on 08/13/2025 at 2:50 PM stated her expectations were that meals be served at the time posted. ADMN stated meals were not being served on time due to a large turnover in kitchen staff. ADMN stated meal service not being on time can affect the resident's medication routine and activities of daily living such as showers and incontinent care. ADMN stated the residents had an expectation of meals being served on time. ADMN stated meal service times are monitored by department heads. ADMIN stated had been trying to hire more kitchen staff but had not had many qualified applicants. Record review of facility's grievance log residents filed a grievance concerning late meals in April, May, June and July of 2025. Record review of facility's policy titled: Food and Nutrition Services (no dated) revealed Policy statement: Each resident is provided with a nourishing palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preference of each resident. 3. Meals and/or nutritional supplements will be provided within 45 minutes of either resident request or scheduled meal time, and in accordance with the resident's medication requirements. 9. Meals are scheduled at regular times to assure that each resident receives at least three (3) meals per day. Mealtimes are posted in facility common areas.</p> | | |