

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/17/2026
NAME OF PROVIDER OR SUPPLIER  Woodville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  102 N Beech St Woodville, TX 75979	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were completely documented for 2 of 7 residents reviewed for complete medical records. (Residents #1 and #2) * The facility did not have any documentation of Resident #1 having elopement behaviors prior to her placement on the secured unit. * The facility did not have orders for Residents #1 and #2 to reside on the secured unit. This failure could place residents at risk of restraint and isolation. Findings included:1. Record review of a face sheet dated 01/17/26 indicated Resident #1 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and dementia (loss of cognitive functioning). During an observations on 01/17/26 from 12:00 p.m. through 04:00 p.m. indicated Resident #1 was residing on the secured unit of the facility. Record review of a list provided by RN A on 01/17/26 at 12:55 p.m. indicated Resident #1 was placed on the secured unit in the last 3 months. Record review of an Elopement Risk assessment dated [DATE] indicated Resident #1 had no history of elopement or an attempted elopement while at home; no history of elopement or attempted leaving the facility without informing staff; did not verbally express the desire to go home or pack belongings to go home; and did not wander with a specific destination in mind, attempting to open secured doors, trying to leave the facility to go home, etc. Record review of the quarterly MDS dated [DATE] indicated Resident #1 had severely impaired cognition with a BIMS of 00 out of 15 and she had no behaviors. Record review of a care plan dated 12/31/25 indicated Resident #1 had risk for wandering/elopement identified with appropriate interventions. Record review of Nurse Notes from 11/17/25 through 12/26/25 indicated Resident #1 had no exit seeking behaviors. Record review of an Elopement Risk assessment dated [DATE] indicated Resident #1 had history of elopement or attempted leaving the facility without informing staff; and had wandering with a specific destination in mind, attempting to open secured doors, trying to leave the facility to go home, etc. Record review of physician orders for January 2026 indicated Resident #1 had no order for placement on the secured unit. During an interview on 01/17/26 at 12:56 p.m. RN A said Resident #1 was her family member and was placed on the secured unit a few weeks ago. She said the resident was having exit seeking behaviors at times wanting to go out and down the road to find her husband. She said the facility contacted the RP about this and the RP agreed to place her on the unit for her safety. 2. Record review of a face sheet dated 01/17/26 indicated Resident #2 was admitted on [DATE] and readmitted on [DATE]. Her diagnosis included dementia (loss of cognitive functioning). Record review of an Elopement Risk assessment dated [DATE] indicated Resident #2 was not bedfast or non-ambulatory; did not have a history of elopement or an attempted elopement while at home; did not have a history of elopement or attempted leaving the facility without informing staff; did not verbally expressed the desire to go home or packed belongings to go</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  675120	Facility ID:  675120  If continuation sheet Page 1 of 3

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>home; and did not wander with a specific destination in mind, attempting to open secured doors, trying to leave the facility to go home, etc. Record review of Nurse Notes for Resident #2 indicated the following entries:* on 11/28/2025 at 03:39 p.m. Attempted to administer resident Rocephin antibiotic shot to treat UTI in progress. Resident noted with increased agitation and restlessness. Refused for staff to administer medication. Resident currently in room, rummaging through drawers. No symptoms of distress noted. Ambulating with walker.* on 11/29/2025 at 12:37a.m. Resident continues to refuse medications. Resident states, No, I am not taking anything from any of ya'll. I don't know, but I think ya'll all be in this together. I don't know what ya'll are trying to give me. * on 12/01/2025 at 12:23 a.m. Resident had been paranoid that family members are trying to take her money away. Resident had periods of forgetfulness. Resident at times thinks that she still has an apartment that she needs to pay the rent for. Thinks that she needs to go to the hospital so things can get straightened out money wise. Resident thought that we, the facility are trying to poison her and will refuse medications at times. Resident thinks that we are on her family member's side. Attempted to explain to resident the situation, where she was but does not believe staff.* on 12/01/2025 at 09:00 resident was given lorazepam as prn order for agitation, yelling, anxious. Continued with paranoia regarding family issues, thinks facility was trying to poison her, refuses meds at times.* on 12/01/2025 at 06:00 p.m. Resident is upset stating that her son and sister are up to no good. Resident is yelling and cursing saying, we can't hold her here like a prison. Resident states you are trying to poison me; you aren't even a nurse Resident has been anxious and very paranoid. Notified MD, psychiatric referral in, unable to give prn Ativan due to resident not trusting staff. MD aware. Record review of an Elopement Risk assessment dated [DATE] indicated Resident #2 was not bedfast, non-ambulatory or unable to self-propel in a wheelchair independently; and had been seen packing belongings to go home without a discharge plan in place. Record review of Nurse Notes for Resident #2 indicated an entry on 12/03/2025 at 04:01 p.m. Resident moved to the unit from 200 hall, resident is alert and oriented to self with no acute distress noted, RP made aware of room change, resident tolerated adjustment well, resident orientated to room, and call light in reach. Record review of the quarterly MDS dated [DATE] indicated Resident #2 had moderately impaired cognition with a BIMS of 08 out of 15 and had no behaviors. Record review of physician orders for January 2026 indicated Resident #2 had no order for placement on the secured unit. Record review of a care plan dated 01/17/26 indicated Resident #2 was at risk for elopement as evidenced by history of attempts to leave facility. Resident wanders aimlessly. Appropriate interventions were in place. During an observations on 01/17/26 from 12:00 p.m. through 04:00 p.m. indicated Resident #2 was residing on the secured unit of the facility. During a phone interview on 01/17/26 at 11:35 a.m. Administrator B said residents on the Memory Care Unit have to meet criteria to be placed on the unit. She said they had not had any residents that recently moved to the unit that she could think of at the time. She said most residents initially admitted to the unit due to history of elopement/wandering at home or another facility. She said if a resident had exit seeking behaviors after they were admitted to the facility then they would be assessed, permission from the family, an order obtained from the physician, and it should all be documented in the resident's chart. During an interview on 01/17/26 at 11:55 a.m. LVN C said Resident #1 had moved to the secured unit a few weeks ago due to having issues with trying to get out of the building. She said Resident #2 had been moved to the secured unit also because of saying they were trying to keep her prisoner when she would head to one of the doors. She said they monitor them with the others to ensure they do not elope, but she can wander around the unit. During an interview on 01/17/26 at 12:56 p.m. RN A said they had a criteria that had to be met for placement on the secured unit. She</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>said there should be documentation in the clinical record to show why an Elopement Risk Assessment was done and why the resident was moved to the secured unit. She said they had to have an order from the physician also to place someone on the secured unit. She said if documentation was not done or an order was not received there would be no indication as to why a resident was placed on the secured unit and the record would be incomplete. During an interview on 01/17/26 at 03:52 p.m. Administrator D indicated residents should have placement on the Memory Care unit assessed, an order written, and a care plan addressing placement otherwise they could be inappropriately placed on the unit. Record review of an admission Criteria for Memory Care Program dated 02/01/23 indicated POLICY: Criteria have been established for admission to the Memory Care Program when the patient's needs warrant placement into secured care. admission to the Memory Care Program must meet the criteria and must be approved by the IDT. PROCEDURE:1. A patient's placement into the Memory Care Program is based upon an interdisciplinary assessment of the resident's cognitive and functional status. 2.A patient's placement or transfer to the Memory Care Program is determined at such time as a patient constitutes a need to be in a safer environment that provides quality of life within the limits of the facility's ability or is determined to be a wandering or elopement risk.5. The patient representative for the resident will be contacted regarding placement in the Memory Care Program pending room available.</p>		