

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2025
NAME OF PROVIDER OR SUPPLIER  Dogwood Trails Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  647 US Hwy 190 W 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)
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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported, immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or bodily injury, to the administrator of the facility and to other officials, including the State Survey Agency in accordance with State law through established procedures for 1 of 8 residents (Resident #8) reviewed for reporting allegations of abuse. The DON failed to ensure allegations of verbal abuse were reported to the Abuse Coordinator immediately or to the sState within 2 hours. On 06/09/25 at an unknown time, Resident #8 alleged to the Activity Director that MA C hated her and yelled at her. The Activity Director provided the allegation on a grievance to the DON on 06/09/25 at an unknown time. This failure could place residents at risk of abuse, neglect, and exploitation. Findings included: Record review of Resident #8's face sheet dated 07/09/25 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included Alzheimer's (brain condition that progressively damages memory, thinking, and learning skills), depression (mood disorder), moderate dementia (decline in cognitive function) with anxiety (feelings of dread and inner turmoil), dementia with mood disturbance, dementia with behavioral disturbance, and unspecified psychosis (presence of psychotic symptoms such as hallucinations). Record review of Resident #8's quarterly MDS assessment dated [DATE] indicated she was usually understood and usually understood others and had moderate cognitive impairment (BIMS-10). There were no behavioral symptoms noted. Record review of Resident #8's care plan dated 01/31/23 indicated Resident #8 had a history of making false allegations. Interventions included notify family and the MD of any changes in condition, attempt to locate items PRN, and encourage resident to search for items. Record review of Resident #8's care plan dated 02/21/23 indicated she hallucinated and had delusions. Interventions included intervene as necessary to protect the rights and safety of others in a calm manner, divert attention, remove from the situation and take to another location as needed. Record review Resident #8's care plan dated 03/05/25 indicated Resident #1 was sexually active and would undress in front of open windows and others (roommates) and would not close her curtains or privacy curtain. Interventions included evaluate the ability to understand behavior and consequence of that behavior. Record review of Resident #8's Grievance/Complaint report dated 06/09/25 and completed by AD AA, indicated she alleged MA C hated her and yelled at her. She said MA C yelled at her about taking a shower. The DON was assigned the grievance on 06/09/25. The DON documented she spoke with MA C. MA C stated she did not hate Resident #8. She tried to redirect her because she dressed inappropriately with little robe on and her breast was almost hanging out. MA C asked her to put some clothes on and Resident #8 got upset with MA C. MA C was educated on better customer service. The prevalence was resolved with one-to-one discussion on 06/12/25. The DON completed the grievance form on 06/12/25. There was no documentation the allegation of verbal abuse was reported. During an interview on 07/08/25 at 1:40 p.m., the Administrator said she was the abuse preventionist. She said she was not aware of Resident #8's Grievance/Complaint report dated 06/09/25. She said the previous SW must have placed the grievance in the binder after the DON completed the form. She said the allegation of verbal abuse was reportable. She said residents were at risk of further abuse if allegations were not reported as required. During an interview on 07/08/25 at 2:01 p.m., MA C said she did not hate Resident #8 and did not yell at her. She said on 06/09/25 Resident #8 was walking through the dining area with her breast almost hanging out of her robe. She said she directed her to put on proper clothes. She said verbal abuse should be reported to the Administrator and/or the DON/designee immediately. She said residents were at risk of further abuse if allegations were not reported as required. During an interview on 07/09/25 at 9:40 a.m., the DON said when she received Resident #8's Grievance/Complaint report dated 06/09/25, she did not take the allegations as verbal abuse. She said she could not recall the time she received the complaint. She said the allegations should have been reported within two hours to the sState. She said residents were at risk of further abuse if allegations were not reported as required. During an interview on 07/09/25 at 11:38 a.m., AD AA said Resident #8 came into his office on 06/09/25 and alleged MA C said she hated her and yelled at her. He could not recall the time. He said he completed the grievance form and immediately took it to the DON. He said he did not witness the alleged event. He said residents were at risk of further abuse if allegations were not reported as required.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 investigate and report the findings of the investigation to the State Survey Agency within 5 working days of the incident for 1 of 8 residents (Residents #8) reviewed for abuse. The facility failed to investigate and submit the results of their investigation within 5 days after Resident #8 alleged MA C yelled at her on 06/09/25. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Findings included: Record review of Resident #8's face sheet dated 07/09/25 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included Alzheimer's (brain condition that progressively damages memory, thinking, and learning skills), depression (mood disorder), moderate dementia (decline in cognitive function) with anxiety (feelings of dread and inner turmoil), dementia with mood disturbance, dementia with behavioral disturbance, and unspecified psychosis (presence of psychotic symptoms such as hallucinations). Record review of Resident #8's quarterly MDS assessment dated [DATE] indicated she was usually understood and usually understood others and had moderate cognitive impairment (BIMS-10). There were no behavioral symptoms noted. Record review of Resident #8's care plan dated 01/31/23 indicated Resident #8 had a history of making false allegations. Interventions included notify family and the MD of and changes in condition, attempt to locate items PRN, and encourage resident to search for items. Record review of Resident #8's care plan dated 02/21/23 indicated she hallucinated and had delusions. Interventions included intervene as necessary to protect the rights and safety of others in a calm manner, divert attention, remove from the situation and take to another location as needed. Record review Resident #8's care plan dated 03/05/25 indicated Resident #1 was sexually active and would undress in front of open windows and others (roommates) and would not close her curtains or privacy curtain. Interventions included evaluate the ability to understand behavior and consequence of that behavior. Record review of Resident #8's Grievance/Complaint report dated 06/09/25 and completed by AD AA, indicated she alleged MA C hated her and yelled at her. She said MA C yelled at her about taking a shower. The DON was assigned the grievance on 06/09/25. The DON documented she spoke with MA C. MA C stated she did not hate Resident #8. She tried to redirect her because she dressed inappropriately with little robe on and her breast was almost hanging out. MA C asked her to get some clothes on and Resident #8 got upset with MA C. MA C educated on better customer service. The prevalence was resolved with one-to-one discussion on 06/12/25. The DON completed the grievance form on 06/12/25. There was no documentation the allegation of verbal abuse was reported. During an interview on 07/08/25 at 1:40 p.m., the Administrator said she was the abuse preventionist. She said she was not aware of Resident #8's Grievance/Complaint report dated 06/09/25. She said the previous SW must placed the grievance in the binder after the DON completed the form. She said the allegation of verbal abuse was reportable. She said she did not conduct an investigation and submit a report within 5 days to HHSC. She said residents were at risk of further abuse if allegations were not reported as required and investigations were not completed. During an interview on 07/08/25 at 2:01 p.m., MA C said she did not hate Resident #8 and did not yell at her. She said on 06/09/25 Resident #8 was walking through the dining area with her breast almost hanging out of her robe. She said she directed her to put on proper clothes. She said verbal abuse should be reported to the Administrator and/or the DON/designee immediately. She said residents were at risk of further abuse if allegations were not reported as required. During an interview on 07/09/25 at 9:40 a.m., the DON said when she received Resident #8's Grievance/Complaint report dated 06/09/25, she did not take the allegations as verbal abuse. She said she could not recall the time she received the complaint. She said the allegations should have been reported within two hours to the sState. She said residents were at risk of further abuse if allegations were not reported as required. During an interview on 07/09/25 at 11:38 a.m., AD AA said Resident #8 came into his office on 06/09/25 and alleged MA C said she hated her and yelled at her. He could not recall the time. He said he completed the grievance form and immediately took it to the DON. He said he did not witness the alleged event. He said residents were at risk of further abuse if allegations were not reported as required. During an observations and interview on 07/09/25 at 1:00 p.m., Resident #8 appeared appropriately dressed in a dress and leggings. Her hair was clean and brushed. She said she had no complaints of her care or staff. She said she did not recall any staff yelling at her. Record review of the facility's Abuse/Neglect policy dated 09/09/24 indicated: F Reporting 1. Any person having reasonable cause to believe an elderly or</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</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 residents received adequate supervision to prevent accidents for 2 of 8 residents (Resident #1 and Resident #2) reviewed for supervision to prevent accidents. The facility failed to ensure Resident #2 was free from physical abuse when Resident #1 hit Resident #2 on 06/08/25 on the secure unit. The facility failed to provide training regarding 1-1 or notify management of 1-1 status. CNA A was the only staff assigned to the unit. After the altercation, CNA A was also assigned to provide 1-1 for 1.5 hours for Resident #1 but took Resident #2 with her as she cared for other residents and did not provide 1-1 for Resident #1. The facility failed to ensure Resident #1 and Resident #2 did not hit each other on 06/17/25 on the secure unit. CNA A did not request assistance when she was providing care to another resident. CNA A was assigned to the unit and assigned to provide 1:1 for Resident #1 from 9:30 a.m. to 12:45 p.m. She had to take Resident #1 with her while providing care for other residents. MA C was assigned 1:1 for Resident #2 from 9:30 a.m. - 1:00 p.m. There was no additional staff assigned to provide care and supervision for the remaining residents on the unit. The facility did not review, update, or implement interventions to include adequate supervision and continued to leave Resident #1 alone and unsupervised with Resident #2 and with other residents. There was no documentation of who discontinued the 1:1 monitoring of Resident #1 or Resident #2. A De-escalation Techniques training was provided following the second incident. It did not address staff 1:1, notifying management of escalation behaviors, or identifying escalating behaviors. The behavior management policy did not address 1:1 monitoring when residents had escalated/aggressive behaviors or if management would be notified. The facility did not have a system in place to ensure residents were supervised in the secured unit while the assigned staff was providing care for other residents. An Immediate Jeopardy (IJ) was identified on 07/10/25 at 2:25 p.m. The IJ template was provided to the facility on [DATE] at 2:48 p.m. While the IJ was removed on 07/11/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk for emotional distress, fear, decreased quality of life, and further abuse. Findings included: Record review of Resident #1's face sheet dated 07/08/25 indicated she was a [AGE] year-old female who was admitted on [DATE]. Her diagnoses included Alzheimer's (brain condition that progressively damages memory, thinking, and learning skills), severe dementia (loss of cognitive function) with agitation, and anxiety (feelings of dread and inner turmoil). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was usually able to make herself understood and usually understood others, had severe cognitive impairment (BIMS-4), and had behavioral symptoms not directed at others. Record review of Resident #1's care plan dated 06/09/25 indicated Resident #1 had potential to exhibit physical behaviors. Interventions included give resident as many choices as possible about care and activities, if Resident #1 had physical behavior towards another resident, immediately intervene to protect the residents involved and call for assistance, if intervening would be unsafe, call out for staff assistance immediately, notify the charge nurse of any physically abusive behaviors, restarted Buspirone, Resident #1 was separated from other resident, and one-to-one monitoring until determined safe, and secure care consult referral, and when Resident #1 becomes agitated: intervene before agitation escalates. Record review of Resident #1's late entry progress note dated 06/08/25 at 10:15 p.m., completed by RN D, indicated she was notified by CNA A Resident #1 hit Resident #2 with an open hand. The physician and the RP were notified. Resident #1 was restarted on Buspar (Buspirone) (anti-anxiety medication). Record review of Resident #1's progress note dated 06/17/25 at 9:35 a.m., completed by LVN E indicated MA B reported she was outside the secure unit and Resident #1 and Resident #2 being physically combative with each other. There were no injuries noted. Residents were separated with no further events. The MD and the RP were notified. Record review of Resident #2's face sheet dated 07/08/25 indicated she was an [AGE] year old female, admitted on [DATE] and her diagnoses included Alzheimer's and severe dementia with anxiety. Record review of Resident #2's quarterly MDS dated [DATE] indicated she was rarely able to make herself understood, sometimes understood others, had severe cognitive impairment (BIMS-3), and had physical and verbal behaviors directed at others (behavior of this type occurred 1-3 days). Record review of Resident #2's care plan dated 06/18/25 indicated Resident #2 had potential to demonstrate physical behaviors due to dementia and poor</p>