STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675152	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dogwood Trails Manor	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a baseline care plan, or comprehensive care plan with necessary information within 48 hours of the resident's admission for 1 of 7 residents (Resident #101) reviewed for new admissions. The facility failed to develop a baseline care plan within 48 hours of admission for Resident #101 when the resident was admitted on [DATE]. This failure could lead to residents not receiving necessary care and decreased quality of life.Findings included: Record review of Resident #101's face sheet dated 10/06/2025 indicated a [AGE] year-old male admitted to the facility on [DATE] and discharged to an acute care hospital on [DATE] (6 days total). Resident #101's diagnoses included cerebral infarction (condition where blood flow to the brain is interrupted leading to tissue damage), interstitial pulmonary disease (chronic lung disease that leads to scarring of the tissue and a decline in lung function and breathing) and Dementia (symptoms of cognitive decline such as memory loss, reduced thinking ability, and language difficulties that interfere with daily life). Record review of Resident #101's physician order summary indicated he was admitted [DATE] with diagnoses of dementia, cerebral infarct and was prescribed oxygen at 2 to 4 liters per nasal canula (xa flexible tube with two prongs that deliver supplementary oxygen directly into a person's nostrils) as needed for interstitial pulmonary disease with a start date of 09/16/2025. Record review of Resident #101's comprehensive care plan initiated 09/16/2025 indicated he had impaired cognitive function, had diabetes, was a full code and had a history of stroke. Record review of Resident #101's Assessment list on 10/06/2025 indicated a Baseline Care Plan acknowledgement initiated by LVN A but did not indicate a baseline care plan was completed. Record review of Resident #101's Baseline Care Plan Acknowledgement signed 09/12/2025 indicated a copy of the baseline care plan was provided to the resident by LVN A. During an interview on 10/06/2025 at 5:09 p.m., ADON said the charge nurse admitting a resident was responsible for initiating the baseline care plan. She said the nurses were educated on completion of baseline care plans. ADON said DON and ADON were the backup to double check and ensure the baseline care plan was completed within 24 hours of admission. ADON said the DON started Resident #101's comprehensive care plan on Monday morning (09/16/2025) when she returned to work. She said Resident #101's baseline care plan was overlooked. The ADON said the resident risk of a baseline care plan not initiated and completed within 48 hours of admission was the staff may be unaware of a resident's needs. During an interview on 10/06/2025 at 5:17 p.m., the DON said the charge nurse admitting the resident was responsible for initiating and completing the baseline care plan and herself and the ADON were the backup to ensure it was completed. The DON said she initiated Resident #101's comprehensive care plan on Monday morning (09/16/2025) but she could start initiating the baseline care plans for all new admissions that arrived over the weekend so this would not happen again. She said the admitting nurse overlooked initiating a baseline care plan when Resident #101 admitted late on Friday evening (10/06/2025). The DON said the resident risk of a baseline care plan not initiated within 48 hours of admission was the staff may not be able to see the Kardex (an electronic platform that provides a quick overview of essential patient information for nursing care) and be unaware of the care a resident needed. She said her expectation was all newly admitted residents have a baseline care plan completed within 48 hours of admission. During an interview on 10/06/2025 at 5:19 p.m., the Administrator said the charge nurse admitting a resident was responsible for initiating the baseline care plan and the DON and the ADON were the backup to ensure it was initiated. She said Resident #101's baseline care plan was overlooked. The Administrator said the resident risk of a baseline care plan not initiated within 48 hours of admission was the staff may be unaware of the plan of care for staff to follow for a resident to get his needs met. She said her expectation was that all new admissions have a baseline care plan completed within 48 hours of admission. During an interview on 10/06/2025 at 5:22 p.m., LVN A said she was responsible for admitting Resident #101 on 09/12/2025. She said she did not know how to initiate a baseline care plan and thought the RN was responsible for initiating a baseline care plan. LVN A said the resident risk of a baseline care plan not completed within 48 hours of admission was a possibility of the resident not being cared for properly and the staff may be unaware of needed care. Record review of an undated facility policy titled, 'Base Line Care Plans Indicated Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the