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	03/04/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 7 residents reviewed for misappropriation of resident property. (Resident #1) The facility failed to keep Resident #1 free of misappropriation of property when HSK A took Resident #1's Android cell phone, changed her account password, ordered an iPhone 15, and was having it delivered to his address, and was trying to order an IPhone 17. This failure could place residents at risk for decreased quality of life, misappropriation of property, and compromised dignity. Findings included:Record review of a face sheet dated 03/04/26 indicated Resident #1 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), atrial fibrillation (a type of irregular heartbeat), and hypertension (a condition in which the force of the blood against the artery walls is too high). Record review of an admission MDS assessment dated [DATE] indicated Resident #1 had adequate hearing with no hearing aid, had clear speech, was able to make herself understood, was able to understand others, was cognitively intact with a BIMS of 13 out of 15. Record review of the care plan dated 02/08/26 indicated Resident #1 had impaired cognitive function/dementia or impaired thought processes. During an interview on 03/04/26 at 10:25 a.m. the Administrator said Resident #1's cell phone was reported missing on 02/26/26. She said they had looked in the laundry and had retraced Resident #1's steps to determine if she left it somewhere or if it was mixed in with the linen. She said the family out of state that was over the phone account contacted her and said they had received some unusual emails about the phone and about the account, so the family sent the emails to her. She said the family said they paid approximately $85 for the phone Resident #1 had. She said when she received the emails on 03/01/26 she realized the phone was stolen and not just missing. She said a new iPhone, valued at approximately $500 was ordered to be delivered at an address that was not the family's address or the facility's address. She said when she cross referenced the address it belonged to HSK A. She said she came to the facility on [DATE] to report the incident and notify the police. She said she was also going to suspend HSK A. She said she waited until the Deputy arrived to talk with HSK A to suspend him. During an observation and interview on 03/04/26 at 12:15 p.m. Resident #1 was interacting with staff with no issues. She said she was doing fine. She said she had an issue with a young man with curly hair that took her phone. She said her family was dealing with it. She said the police were at the facility one day and the young man caused a ruckus. Record review of a Provider Investigation Report dated 03/06/26 indicated the incident occurred on 02/26/26 and it was reported to HHSC on 03/01/26 when the facility was made aware of the cell phone being stolen and not just missing with HSK A listed as the Perpetrator. Resident #1's family provided emails from the phone service provider indicating an iPhone 15 was purchased and was to be delivered to HSK A's address. HSK A had worked the day the phone was missing. Police were notified on 03/01/26 and arrived to the facility to make a report. HSK A was working and was suspended. The officer did arrest the accused HSK A. Police investigation was in progress. Resident #1's family planned to press charges on perpetrator when the police investigation was completed. Perpetrator HSK A was terminated on 03/05/26. Record (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of emails from phone service provider provided by Resident #1's family member indicated the following:* 02/27/26 at 05:05 p.m.Mobile number ending in [####] now has access to [Provider] Cloud Unlimited Individual. Photos, videos, and more can be securely stored and accessed with [Provider] Cloud.* 02/27/26 at 05:49 p.m. indicated an iPhone 17 Pro Max 2TB phone was still in the purchasing cart. * 02/27/26 at 06:19 p.m. indicated an order was received #[########]with a payment of $73.48 billed Resident #1's family member. A receipt was also in the email for an iPhone 15 to be delivered to HSK A's home address and delivery date to be 02/28/26.* 02/27/26 at 08:49 p.m. indicated there was a request to change the password to the account. * 02/27/26 at 08:54 p.m. indicated [Provider] noticed a sign-in to the account from a device not recognized. Details indicated the account was registered to mobile number ending ####, Resident #1's phone number. * 02/27/26 at 09:06 p.m. indicated the Account Manager from the account was removed.* 02/27/26 at 09:47 p.m. indicated the password was updated. * 02/27/26 at 10:04 p.m. indicated there was a new account mailing or billing address. * 02/28/26 at 08:33 a.m. indicated the account was updated to de-enroll the email receiver from the online account. * 02/28/26 at 09:03 a.m. indicated order #[########] was canceled. Record review of an undated Affidavit of Probate obtained from the local police department indicated on 03/01/26 a Deputy was dispatched to the facility for a Theft of Property call involving HSK A. When the Deputy arrived, he made contact with the Administrator who informed him they had an issue with a worker who stole a cell phone from one of the residents and changed all the passwords for phone account in the process. She also informed him that the individual who took the phone also just purchased a new iPhone 15 on the resident's phone plan without her consent and the phone was to be delivered to [address]. He indicated the address was looked up in the nursing home's system and it was the address of HSK A. HSK A happened to be working at the time the Deputy arrived and asked the Administrator to bring him to the office so they could talk about the phone. The Deputy placed HSK A into custody and he was removed from the facility. Record review of an undated Abuse/Neglect Policy indicated The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.Definitions:. 9. Misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. HSK A was not available for interview as he was still in police custody.