STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675229	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing and Rehabilitation	99 Rigby Owen Rd Conroe, TX 77304

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to serve foods that were palatable and attractive and prepare food by methods that conserve nutritive value, flavor, and appearance for 4 (Resident #1, #2, #3, and #4) of 7 residents reviewed. 1. Resident #3 revealed pictures of meals on 06/26/25, 06/23/25, and 06/22/25 that showed small meal portions with unpalatable and unrecognizable food items. 2. A test tray was provided for the lunch meal service that contained a chopped steak that resembled a slab of meat covered in gravy and a hashbrown casserole that was bland and gummy. These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life. Findings included:Record review of Resident #1' s face sheet revealed a [AGE] year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were Hemiplegia and hemiparesis (loss of strength and weakness to a side of the body) and vascular dementia. Record review of Resident #2' s face sheet revealed a [AGE] year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were diabetes mellitus due to underlying condition with diabetic neuropathy (pain, tingling, or numbness in the hands or feet related to diabetes), Benign neoplasm of meninges (tumors that develop from the membranes surrounding brain and spinal cord), and lack of coordination. Record review of Resident #3' s face sheet revealed a [AGE] year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were hypertension (high blood pressure), Stage 3 Chronic Kidney disease, and Type 2 Diabetes. Record review of Resident's #4's face sheet revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were cerebral edema (brain swelling), anoxic brain damage (brain injury where the brain loses oxygen), and unsteadiness on feet. In an observation and interview on 06/27/25 at 2:28 pm, Resident #1, #2, and #3 were sitting in a room enjoying a game. Resident #1, #2, and #3 stated unanimously that they have a strong aversion to the food and often have to order food from outside of the facility to feel satisfied. Resident #1 expressed that he always received his food cold and stated that although the aides could warm it up, he wanted to receive his food like it was when it was first cooked. When asked if he would go to the dining room during meal services, Resident #1 refused and stated his preference was to enjoy his meals in his room. Resident #1 added that he recently (date unknown) received a biscuit that was overcooked on top and raw on the inside, expressing that he felt the dietary requirements were not right at the facility and he inquired where his payments were going. Resident #1 explained that sometimes he would refuse medication because some of the meds he took required food and he would not take them on an empty stomach. Resident #3 explained that all three of the men were diabetics and it was important that they not only ate, but received enough food with access to snacks. Resident #2 agreed that he did not get large enough portions and explained that for dinner on 06/26/25 he received a piece of turkey, lettuce and a tortilla, and that was not enough to hold them overnight. Resident #2 stated that the two men who worked in the kitchen were lazy and recalled how he received grits for breakfast that were as hard as a baseball. During this conversation, Resident #3 interjected and stated that he had been taking pictures of the food they had been receiving during meals. Record review of the pictures shared by Resident #3 detailed the following:1. For dinner on 06/26/25 at 5:40pm, residents received a roll, creamed peas, a white tortilla with a small piece of lettuce, a possible piece of meat, and a heavy serving of a white sauce drenched across that tortilla. The food was hard to identify and did not look attractive. 2. For breakfast on 06/23/25 at 7:43 am, he received oatmeal that was shaped in a dome as if it was scooped out with an ice cream scooper and a Cinnabon with frosting. 3. For dinner on 06/22/25 at 5:51pm, he received one piece of what appeared to be a fried chicken strip, a roll, a very small scoop of peas, and a scoop of a red vegetable that could not be identified by Resident #3 or the investigator. In an interview on 06/27/25 at 2:36 pm, the DM stated that she had been working at the facility for 2 years and she started off as a cook. She explained that food was served first in the dining room and came to the halls after all the residents had received a plate. She admitted that she had received complaints regarding the food being cold and portion sizes from Resident #1, Resident #2, and Resident #3. She stated that when the trays came, the staff would let them sit on the hall and delayed passing them out immediately. The DM explained that she had spoken to the DON and nurses about the hall trays and suggested to get additional help from other staff to get trays out faster and to get more residents into the dining room for a hot plate. The interview was cut short due to the DM having prior engagements. In an observation on 07/02/25 at 9:45 am in the kitchen, a pack of ground beef sat in the sink

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation in that: 1. [NAME] A placed a 10lb pack of ground beef in the sink underneath running hot water to defrost for lunch service. 2. Intern A failed to secure her waist length hair in a hair net. 3. [NAME] A failed to use gloves when handling the ground beef for lunch service. 4. During a food temperature check, [NAME] A placed the thermometer in each item of food without properly sanitizing the thermometer between checks. 5. [NAME] A failed to wash hands before utilizing gloves. 6. [NAME] A touched the top of the trashcan with his gloved hands and proceeded to prepare a test tray for the investigator. 7. For lunch service, Resident #1 received food that fell below safe temperatures for hot foods during his lunch service on 07/02/25. The temperatures of the hashbrowns were 128 degrees F and string beans were 118 degrees F. These failures could place residents at risk of foodborne illnesses. The findings included:Record review of Resident #1' s face sheet revealed a [AGE] year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were Hemiplegia and hemiparesis (loss of strength and weakness to a side of the body) and vascular dementia. In an observation on 07/02/25 at 9:45 am in the kitchen, a pack of ground beef sat in the sink and while hot water ran over the meat and a gulf of steam came off of the water. [NAME] A came over and turned the water off and took the meat out of the sink with his bare hands and placed it on a silver tray. There was a handwashing sink a few feet away from where the meat was being thawed, however, [NAME] A did not wash his hands prior to grabbing the meat. Intern A had long orange hair that hung to her waist that was not covered with a hair net. [NAME] A could be observed minutes later mixing the ground beef with his bare hands in a silver pan. The menu for 07/02/25 displayed that lunch for that day would consist of smothered chopped steak, hash brown casserole, green beans, garlic cheese biscuit, banana pudding desert, and a beverage. On a bulletin board, DA A and [NAME] A displayed up to date food service certifications. In an interview on 07/02/25 at 9:59 am, Intern A stated she had been interning in the kitchen as a dietary aide for 4. 5 weeks and her last day would be July 11th. Some of her job duties included wrapping silverware for meal services, filling tea cups, clean up, and occasionally serving food in the dining room. In an interview on 07/02/25 at 10:03 am, [NAME] A stated that he had worked as a cook in the kitchen for almost 2 months and his schedule was 6am-6pm daily. He explained that when he took the meat out of the sink, he seasoned it and spread it flat in the silver pan. He stated that since they were serving smothered steak, the DM told him it would be better to cook that way. [NAME] A stated that he didn't normally unthaw meat using hot water but it was taking a long time to thaw out. He stated his normal practice was to place it in a pan of room temp water. When asked what the health concerns were of running partially frozen ground beef under hot water to unthaw and he explained that it depended on the time frame, and [NAME] A had only ran the hot water of the ground beef for 10 minutes. He explained that he worked yesterday (07/01/25), but he forgot to take meat out of the freezer. In an interview on 07/02/25 at 11:14 am, LPN A stated that when the trays came out to the halls for meal services, she tried to push them out immediately. In the past she had gotten complaints of the food being cold, one of the resident's being Resident #1. She explained that when the food was cold, she would take the plate and reheat it in the microwave. In an interview on 07/02/25 at 11:28 am, the AD stated that in a recent Resident Council meeting, he received complaints that the trays being served on the halls were cold. The AD said he explained to the residents that the residents who sat in the dining room were severed first and then trays were pushed out to the halls. He gave them the suggestion to eat their meals in the dining room and the residents understood but they refused to budge, which they have the right to. The AD stated that he also told residents to let the aides know their food was cold and document while he informed the nurses and management. In an observation on 07/02/25 at 11:43 am in the kitchen, the investigator requested temperature checks for the lunch service. [NAME] A grabbed the thermometer out of a basket and walked to the steam table. The temperatures were 200.7 degrees F for the chopped steak, 196. 3 degrees F for the hashbrowns, and 174.4 degrees F for the green beans (range should be over 165 degrees F for hot food). During the temperature checks, [NAME] A took the thermometer from the chopped steak, to green beans, to hashbrowns and did not wipe or sanitize the thermometer between food items. Back in the kitchen, [NAME] A wiped the thermometer off with a paper towel and placed it back into the basket. The investigator requested a test tray to sample and [NAME] A grabbed the plate with his hands, but