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	08/25/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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	08/25/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure adequate supervision and assistance devices to prevent accidents for one of six residents (Resident #1) reviewed for accident hazards in that: -The facility failed to ensure Resident #1 had interventions in place after she fell on 8/10/2025, 8/11/2025, or 8/14/2025 when she sustained a hematoma to her forehead and on 8/16/2025 when she fell again and suffered a laceration over the right eye requiring 7 sutures.-The facility failed to adequately supervise Resident #1 after she experienced the first fall on 8/10/2025. -The facility failed to determine the causative factors of the falls and address those factors timely. Resident #1 was admitted on [DATE]. An Immediate Jeopardy (IJ) was identified on 8/22/2025 at 3:40pm. The IJ template was provided to the facility on 8/22/2025 at 3:40pm. While the IJ was removed on 8/24/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm as the facility continued to monitor the implementation and effectiveness of their plan of removal.This failure could place residents at risk of serious injuries requiring hospitalization or surgical intervention, and/or death.Findings Included:Record review of Resident #1's face sheet dated 8/7/2025 revealed that she was a [AGE] year-old female that was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of hypertension (high blood pressure), other muscle spasms(involuntary contractions of muscles), long-term aromatase inhibitors(used to treat hormone-receptor-positive breast cancer in women), and cervical myelopathy (a nervous system disorder that affects the spinal cord) and a history of falls.Record review Resident #1's care plan dated 8/8/2025 revealed that a 48-hour baseline had been completed. Problem: Baseline care plan will identify my care needs, risks, strengths and goals for the first 48-hoursGoal: Initial goal is to have access of services to promote adjustment to my new living environment. Approach: Safety falls: Fall risk evaluation will be completed to identify and minimize initial risk factors for falls/injury. Record review of Resident #1's initial MDS assessment dated [DATE] revealed:Section C500- Brief Interview for Mental Status was unscored. Section GG01300- Functional Abilities revealed C. toileting hygiene was coded as 04- representing supervision or touching assistance was needed by helper. E. Shower/bathe self was coded as 01-Dependent -helper does all of the work. F. Upper body dressing, lower body dressing, personal hygiene and putting on/taking off footwear were all coded as 3. Representing partial/moderate assistance needed by a helper.Section GG0170- Mobility revealed sit to stand, chair/bed-to-chair-transfer, and toilet transfer were coded as (2)- which represented substantial/maximum assistance-helper does more than half the effort. Helper lifts or holds trunk or limbs and does more than half the effort. Section J1700-Fall History A. Did the resident have a fall any time in the last month prior to entry/entry or reentry was coded 1. YesJ1800- Any falls since admission was coded as 1. Yes Record review of Resident #1's Morse Fall scale dated 8/7/2025 revealed Resident #1 had a history of falls, ambulated with a walker, had weakness, Gait: Normal. There was a score of 40 and she was deemed a low risk for falls.Record review of the morse scoring data revealed five factors for scoring:1. History of Falls (25 points)- Resident #1 has fallen prior to admission2. Secondary Diagnosis (15 points)- Resident #1 has more than one medical diagnosis3. IV Therapy- (0) - Resident #1 does not have an IV4. Gait- (20) points- Resident #1 had impaired gait, difficulty rising or poor balance5. Mental Status- (15 points) - Resident #1 overestimates her ability and is forgetful of their limitations. Low Risk if (Score of 0-24 points)Medium Risk- (Score of 25-44)High Risk (Score of 44 or higher than 50) Record review of Resident #1's admitting hospital record dated 6/25/2025 revealed the resident was admitted to the hospital and assessed due to recent falls, hemiplegia and hemiparesis following cerebral infarction. Record review of the Resident #1's clinical record from a local hospital ER visit dated 8/4/2025 revealed her chief complaint was a fall. She now presents with multiple falls due to myelopathy. CT head was negative however x-ray showed right shoulder mid shaft clavicle fracture comminuted proximal phalanx. Neurology was consulted to decompress her spinal cord as she underwent C3-C4, C4-C5, C5-C6 ACDF on 8/24/2022. She was not wearing her soft collar. Record review of Resident #1's clinical record from ER visit dated 8/14/2025 revealed she was admitted due to a fall at the facility and sustained a head injury and possible lumbar transverse process fracture. Activity instructions were for Resident #1 were to get up using only her walker, take her time standing and ask for assistance when needed. Continue wearing the cervical collar and sling. Record review of Resident #1's ER record dated 8/16/2025 revealed she was admitted to the hospital following a fall with a laceration over her right eyebrow. She received 7 sutures. Record review of Resident