

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  Woodland Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</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 serve foods that were palatable and attractive and prepare food by methods that conserve nutritive value, flavor, and appearance for 3 (Resident #1, #2, and #3) of 6 residents reviewed for food services. 1. Resident #1, Resident #2, and Resident #3 received a piece of undercooked bacon on 04/12/26 on a BLT sandwich served during dinner service. 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, dated 04/22/26, revealed a [AGE] year-old female, admitted [DATE]. Her admitting diagnoses were Hemiplegia and hemiparesis (loss of strength and weakness to a side of the body), dysphagia (difficulty swallowing), a tooth infection, and morbidly obese due to excess calories. Record review of Resident #2's face sheet, dated 04/22/26, revealed a [AGE] year-old male, admitted [DATE]. His admitting diagnoses were diabetes mellitus with a foot ulcer (an open sore, often caused by neuropathy (lack of feeling), poor circulation, and foot deformities), depression, and inappropriate diet and eating habits. Record review of Resident's #3's face sheet, dated 04/22/26, revealed a [AGE] year-old female, admitted [DATE]. Her admitting diagnoses were Stage 2 chronic kidney disease, dementia, (loss of cognitive functioning that interferes with daily life and activities), and unsteadiness on feet. During an observation on 04/22/26 at 1:30 p.m. in the Kitchen, the food handler's certifications for kitchen staff were displayed on a wall near the kitchen entrance. The certifications revealed the DM, DA, and DC had current certifications (dates not captured). During an attempted interview on 04/23/26 at 1:36 p.m., the DC was unable to be located in the facility. During an interview on 04/23/26 at 1:36 p.m., DA stated he was not sure where the DC went. DA stated that he had worked at the facility for 5-6 years and he worked 12 hours shift. He stated he recalled the incident where residents complained of being served raw bacon. He stated that the DC did not cook the bacon crispy because some of the residents were on special diets and it made it hard for them to chew. DA stated he tried a piece of the bacon and he did not think it was raw, but felt it was not cooked as crispy as normal. DA stated the residents who complained about the bacon were given the option of a ham sandwich. DA stated the incident occurred over the weekend, on either 4/11/26 or 4/12/26, during the dinner shift. DA stated the bacon was served on a BLT sandwich. During an observation and interview on 04/22/26 at 1:47 p.m., Resident #1 stated that on 04/12/26, she was served a piece of raw bacon on a BLT sandwich that was accompanied with a soup. She stated that when she received her dinner tray that day, she examined the bacon and immediately noticed how fatty it was and immediately informed the DC about the raw meat. She stated she asked the DC what would consuming raw pork do to her health and he did not know. Resident #1 stated she told the DM she needed to get those boys (DA and DC) educated and that the DM was a fantastic cook. She stated that as a substitution for the bacon, she was provided a turkey sandwich. Record review of a photo captured on Resident #1's cellphone, dated 04/12/26 at 6:01 p.m. revealed the only piece of bacon was covered in more than half of fat that looked translucent clear and tan in color on her BLT sandwich. In an interview on 04/22/26 at 12:54 p.m. the DM stated that she had been working at the facility for 2 years. She stated she was not scheduled on the date of the incident regarding the bacon (continued on next page)</p>

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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>but she was made aware. She stated was shown the picture that was taken by Resident #1 and stated that bacon should have been cooked a little longer. The DM stated she talked to the DC and he told her that piece in the picture was the only piece of bacon cooked that way. The DM told the DC that he could not cook bacon like that, and he needed to make sure it was cooked all the way through by using the thermometer instead of going off of how it looked. She stated since that incident, the DC had not cooked bacon in that manner and had done better since then. The DM stated that she followed up with Resident #1 and she let her know that it was unacceptable and she could not recall receiving other complaints regarding the bacon served on 04/12/26. The DM stated that the harm in eating under cooked bacon was that you could get sick or food poisoning. In an interview on 4/23/26 at 12:59 p.m. with the DON, she stated that she had worked at the facility for 2 weeks, with a start date of 04/13/26. She stated that she viewed the picture of the bacon that was taken by Resident #1 on 04/12/26 and stated that bacon looked raw, terrible, and was unfit to eat. She received additional complaints regarding the bacon served on 04/12/26 from Resident #2 and Resident #3. She stated that the facility had very vocal residents there and they came to her often when they needed to voice concerns. In an interview on 4/23/26 at 1:13 p.m. with the ADM, she stated that she began working at the facility on 03/03/26. She was made aware of the situation of the bacon regarding Resident #1 after the day it happened. When she followed up with Resident #1, she was shown a photo and stated that she thought the bacon looked underdone but she was aware that some people preferred their bacon less crispy. She explained that she was not sure if it looked that way because it was more of a fatty piece of bacon but she did go to the kitchen and informed them that they were supposed to be checking the temperatures on all food. The ADM did not follow up with DC because that was something the DM would communicate. The ADM stated that her expectation of food was aligned with the policy as far as food looking good, smelling good, and tasting good. If there was a meal that a resident did not like, the facility would always have 3 substitution options available upon request. During an interview on 04/23/26 at 1:33 p.m., Resident #2 and Resident #3 stated they were served raw bacon on 04/12/2026. Resident #2 stated that he only received one piece of bacon on his BLT sandwich and was upset because that was supposed to be their evening meal. He stated the DA and the DC did not care and would throw anything together. Resident #2 stated that on the day he was served the bacon, he asked the DC would he eat it, or pay for bacon prepared that way, and he stated that DC responded, well you don't pay for it either. Resident #2 stated that he found this disrespectful because he stated that he paid for everything at the facility and even contributed to the DC's salary. Resident #2 stated a photo of the bacon he received on 04/12/26. Resident #3 agreed with the statements made by Resident #2 and stated that the kitchen is horrible. Record review of a dietary photo received by Resident #2 of the bacon captured on 04/12/26 at 5:30 p.m., showed 1 piece of bacon on a piece of white bread and few pieces of lettuce were pushed to the side of the sandwich. Record review of the 2nd dietary photo received by Resident #2 of the bacon captured on 04/12/26 at 5:43 p.m., revealed a piece bacon that appeared to be completely translucent on the fatty parts of the meat. The lean parts of the bacon looked gray or a pale pink in color and looked limp, evidenced by how the end of the bacon curled over the edge of the plate. A follow up interview attempt was made on 04/23/26 at 11:30 a.m. with DC. He was not scheduled to work that day. Interview attempts via phone were made at 2:21 p.m. and 3:22 p.m. A voicemail and text messages were sent requesting a call back. On 04/24/26 at 10:30 a.m. and 04/30/26 at 10 a.m. additional calls were made to DC. DC did not answer calls, respond to messages, and was unavailable for interview during this investigation. Record review of the facility's policy titled Food Handling revised June 1, 2019, documented that the facility's policy was to ensure that all food served by the facility is of good quality and safe for consumption, all food will be handled according to the state and US Food Codes and HACCP guidelines.</p>		