

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/17/2025
NAME OF PROVIDER OR SUPPLIER  Woodland Springs Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 Dallas St Waco, TX 76704	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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 ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, were reported immediately to the State Survey Agency for incidents of alleged abuse and neglect for one out of eight residents (Resident #1) in that:</p> <p>The facility failed to report to Health and Human Services alleged abuse occurred in the facility secured unit involving Resident #1 and Resident #2. During Resident #1's 05/15/25 LA Update meeting, Resident #1 reported he was hit by Resident #2. The date of alleged occurrence was unknown.</p> <p>This failure could place residents at risk of abuse, neglect, pain, and diminished quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 05/16/25, reflected a [AGE] year-old male original admission date of 08/15/16, and readmissions 08/15/16 and 04/18/25 with diagnoses of paranoid schizophrenia (characterized by delusions of persecution), major depressive disorder, and schizoaffective disorder, bipolar type (a mental health condition characterized by a combination of schizophrenia symptoms (like delusions and hallucinations) and symptoms of bipolar disorder (like mania and depression)).</p> <p>Review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 10 reflecting moderate cognitive impairment.</p> <p>Review of Resident #1's care plan focus revision dated 04/04/25 reflected Resident #1 was PASRR positive for mental illness paranoid schizophrenia/schizoaffective disorder (a mental illness characterized by symptoms of both schizophrenia and mood disorders like mania or depression) with interventions of PASRR services for mental illness.</p> <p>Review of Resident #2's face sheet dated 05/22/25, reflected an [AGE] year-old male original admission date of 10/22/245 with diagnoses of unspecified dementia (a diagnosis given when a person exhibits symptoms of dementia but the underlying cause or specific type of dementia cannot be clearly identified), macular degeneration (a leading cause of vision loss in people 60 and older) and chronic obstructive pulmonary disease (a chronic progressive lung disease that make it difficult to breath).</p> <p>Review of Resident #2's MDS, dated [DATE], reflected a BIMS score 3 reflecting severe cognitive impairment.</p> <p>(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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's care plan focus dated 10/13/24 reflected impaired cognitive function related to dementia (a term for a group of brain disorders that cause a decline in thinking, memory, and reasoning abilities, significantly impacting daily life) with intervention dated 10/13/24 ask yes/no questions to determine resident's needs.</p> <p>Record review of PASRR Comprehensive Service Plan (PCSP) Form dated 05/15/25 for Resident #1 reflected the following:</p> <p>Type of meeting - LA update</p> <p>Reason for meeting - change in service</p> <p>Resident #1 PASRR positive for mental illness only</p> <p>Meeting participants - Resident #1, LA, and facility ADON</p> <p>LA comments reflected - Team met for LA Update to initiate MI PASRR services . [Resident #1] reported another resident assaulting him in his bathroom earlier this month, causing him to hit his head on the toilet resulting in a bump on his head. He stated that the facility would not call 911 and would not allow him to call 911. Team explained to [Resident #1] that the facility staff may have determined that his injury did not require a higher level of care. [Resident #1] . Team encouraged [Resident #1] to follow his medication regimen to ensure that he was not experiencing situations as a result of his mental illness, as he has a history of this. [Resident #1] stated he will continue to refuse his Vistaril.</p> <p>Review of a document dated 05/16/25 listed the sending fax number of the facility and receiving fax number of Health and Human Services intake reporting number and reflected that a self report was made by the facility DON. The document reflected, Please see attached LTC (long term care) facility self-report. Please forward all correspondence to [email for the DON]. The self-repot included Resident #1's client information and the brief narrative reflected, per HHSC (Health and Human Services) surveyor [Resident #1] reported to external cm that he was beat up by a resident and a little girl, sitting on edge of bed. No fax confirmation included with faxed self-report.</p> <p>Record review on 05/16/25 of Texas Unified Licensure Information Portal - the online portal used by healthcare providers in Texas to report various incidents, including those related to abuse and neglect reflected no initial self-report by the facility for an incident involving Resident #1 and Resident #2.</p> <p>Interview on 05/16/25 with Resident #1's PASRR LA at 2:07 pm reflected the ADON was present in the PASRR LA update meeting during the entire meeting including when Resident #1 said Resident #2 assaulted him.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/16/25 with the ADON at 5:54 pm reflected when the PASRR LA representative arrived at the facility for Resident #1's PASRR meeting she was passing out pills to other residents and told Resident #1's LA that she would join the meeting when she was finished passing out the pills. The ADON said it was about 10 or 15 minutes before she joined Resident #1's PASRR meeting. The ADON said at the time she was present during the meeting Resident #1 made no statement that Resident #2 hit him, and Resident #1 made no statement that he told staff he wanted to go to the hospital because of being hit by Resident #2.</p> <p>Interview and observation on 05/16/25 at 1:42 pm with Resident #1 in the facility secured unit revealed Resident #1 said Resident #2 hit him in his head with his fist and there were no witnesses. He said it happened sometime after Resident #1 went to the inpatient psychiatric clinic. Resident #1 said he did not bleed when he was hit, and he pointed to the left side of his forehead head with his right hand and surveyor observed no injury. Resident #1 said he felt safe at the facility, but sometimes other people got into other people's business.</p> <p>Interview and observation on 05/17/25 at 7:52 pm with Resident #2 in the facility secured unit revealed Resident #2 looking at the vending machine and telling the surveyor he wanted crackers. Resident #2 spoke incoherently and pointed at the food items in the vending machine. When Resident #2 was asked if he felt safe at the facility, he said, Yes. Resident #1 was observed in the same area with Resident #2 and no negative interactions were noted between Resident #1 and Resident #2.</p> <p>Interview on 05/17/25 with CNA A at 4:30 pm revealed Resident #1 had not told her that Resident #2 hit him. She said that Resident #1 and Resident #2 share a bathroom and sometimes they yelled at each other, but she had not witnessed or been told by Resident #1 that he was hit or injured by Resident #2. She said if Resident #1 told her that Resident #2 hit him, she would have reported it immediately to the charge nurse. She said that the Administrator was the ANE coordinator, and she would also report ANE to the Administrator. She said she was trained in ANE when she was hired at the facility and the facility conducted in-service training on ANE several times a year. She said everyone was responsible for reporting ANE. She said that she was not concerned about any resident-to-resident abuse in the secured unit but if she saw or heard of any abuse she would report it immediately.</p> <p>Interview on 05/17/25 with RN B at 5:06 pm revealed she worked in the secured unit and Resident #1 never told her that Resident #2 hit him. She said she was not concerned about Resident #1 and Resident #2 having any altercations. She said if there was an allegation of Resident #2 hitting Resident #1, she would separate them immediately, even if the event was not witnessed but reported to her by one of the residents and report it immediately to the Administrator or the DON. She said anyone who heard about or witnessed ANE was responsible for reporting. She said she was trained in ANE when she began working at the facility and she had frequent in-services regarding ANE. She said ANE was a hot topic because it was important to know about what to do if abuse was witnessed or reported and anyone one who saw or heard about abuse was responsible for reporting the ANE.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/16/25 with the facility SW at 6:16 pm revealed she checked on Resident #1 on a weekly basis and put a behavior note in his progress notes for each check-in. She revealed Resident #1 had a history of making allegations that were not true, mostly about the staff. She stated that if he told her that another resident hit him or if he reported he was abused, either witnessed or unwitnessed, she would report it immediately to the Administrator, because he was the Abuse and Neglect Coordinator for the facility. She said that if the Administrator was not available, she would report it to the DON. She said that they could not assume that a resident who had mental health issues or a history of false statements was not abused, it needed to be reported to ensure the safety of the resident. She said she was trained on ANE when she was hired at the facility and she conducted the ANE education, that was based on the facility policy, for new residents who entered the facility so they would know the facility did not tolerate abuse and to education new residents on the types of abuse. She said the facility conducted monthly in-services on ANE education and training.</p> <p>Interview on 05/16/25 with the psychiatric NP at 6:34 pm revealed Resident #1 had a history of refusing to take his medication and recently refused 2 psychiatric telehealth visits with her. She said Resident #1 had mood swings, would curse at the staff, and made a lot of allegations that he was being abused by staff. She said Resident #1 did not tell her that he was hit by Resident #2 but was confident that the facility would have reported it to the state if they were aware the resident made an allegation that he was hit by Resident #2. She said the facility was, on top of it and even if a resident was delusional and reported an allegation of abuse, the facility would still report it.</p> <p>Interview on 05/17/25 with the Administrator at 6:34 pm revealed he was not aware of any abuse regarding Resident #1 until 05/16/25 at about 5:00 pm when he was shown the PASRR Comprehensive Service Plan (PCSP) Form dated 05/15/25. He said the PASRR person did not tell him about any abuse involving Resident #1 and if she knew of abuse, she should have told him. He said the facility had an in-service on abuse and neglect every month. He said if a resident said someone hit them, and the resident had a history of false allegations he would report the allegation to the state regardless of the residents past history of false allegations. He said the allegation involving Resident #1 and Resident #2 was not reported because he was not aware of Resident #1's allegation. He said it was everyone's responsibility in the facility to report ANE and anyone could pick up the phone and call the HHSC hotline, or they could call or tell him about the alleged abuse and he would report all allegations of ANE. He said he did not know the details of what happened during Resident #1's PASRR meeting with the ADON. He felt the PASRR person should have reported it to him even though it was discussed in Resident #1's PASRR meeting. He said the ADON had been trained in ANE and knew how to report ANE.</p> <p>Review of facility in-services reflected in-services on Abuse, Neglect and Exploitation dated 12/18/24, 01/16/25, 02/16/25, 03/05/25, 04/16/25, and 05/15/25.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy Abuse Investigating and Reporting, undated, reflected all alleged violation involving abuse, neglect, exploitation, or mistreatment including injuries of an unknown source and misappropriation of property will be reported by the facility administrator or his/her designee to the following persons or agencies: the state licensing slash certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the Residents Representative (Sponsor) of Record, Adult Protective Services (where state law provides jurisdiction in long-term care), law enforcement officials, the resident's attending physician and the medical director. An alleged violation of abused, neglect, exploitation, or mistreatment (including injuries of unknown sources and misappropriate of resident property) will be reported immediately, but not later than two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury or twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Verbal/written notices to agencies may be submitted via special carrier fax email or by telephone.</p>		