

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 07/15/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect are reported immediately, but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 1 of 7 residents (Resident #1) reviewed for abuse and neglect, in that:Based on interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect are reported immediately, but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 1 of 7 residents (Resident #1) reviewed for abuse and neglect, in that:The facility did not report an incident of potential neglect for Resident #1 to the State Survey Agency within 24 hours, when Resident #1 fell out of his wheelchair while being transported on the facility's van on 06/25/25.This failure could place residents at-risk of not having incident and accident investigations reported within the timeframe required. Findings included:Record review of Resident #1's admission record, dated 06/10/2025, reflected an [AGE] year-old male who was re-admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Chronic kidney disease stage 4 (when your kidneys are damage and can't filter blood properly), type 2 diabetes mellitus without complications (when the body cannot use insulin correctly and sugar builds up in the blood without any common health problems associated with the disease), muscle weakness (reduced ability of the body to contract muscle properly, resulting in a lower strength in one or more muscle), and lack of coordination (having difficulty controlling your movements and making them work together smoothly). Record review of Resident #1's Quarterly MDS assessment, dated 07/08/2025, reflected the resident had a BIMS score of 09, which indicated moderate cognitive impairment. Resident #1 required substantial/maximal assistance in the areas of toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. Resident #1 requires substantial/maximal assistance in the area of shower/bathe self.Record review of Resident #1's care plan, dated 07/15/2025, reflected Resident #1 was care planned for moderate risk for falls r/t unsteady, weak and use of psychoactive, requires assist with ADL's, ADL self-care performance deficit r/t confusion, impaired balance, limited mobility, limited physical mobility r/t weaknessReview of Resident #1's nursing progress note, dated 06/25/25, reflected a progress note entered by the AD that stated, While being transported in [facility name] van from hospital seat belt buckle came loose causing resident to slide onto floor in sitting position resident was at facility when incident occurred witnessed by ADRecord review of Resident#1's witness fall assessment, dated 06/25/2025, reflected was assessed for injuries none noted able to [NAME] was assisted to chair x3 staff and gait.Record review of Resident#1's EMS Patient Care Report, dated 06/25/2025, reflected upon arrival to scene FD is on scene. PT is found inside of a PT transport shuttle for nursing home. Pt was helped up from floor into wheelchair by FD. Pt declines of hurting anywhere and does not want to go to hospital. LVN who was driving the bus stated she hit the brakes too hard and caused Pt to fall out of chair. Once Pt is settled in seat. EMS advise driver to pull out of busy traffic into parking lot to obtain vitals on Pt. Once obtained, Pt still declines wanting to be seen at hospital. Pt is presented with refusal form and educated on risks associated with not being seen at hospital. Pt repeats risk and still declines. Refusal form signed by Pt. Pt declines any other needs at this time.During an interview with Resident #1 on 07/15/2025 at 11:45 AM., Resident #1's stated that he was headed to facility from being picked up at from hospital by the AD in the facility's van. Resident #1 stated they were almost to the facility when the AD hit her brakes, and he slid out of his wheelchair. Resident stated that he was not buckled up when he slid out of his wheelchair. Resident #1 stated both the AD and ADM knew that he slid out of wheelchair due to his seat belt not being buckled. Resident #1 stated that he was not hurt and laughed about the incident. Resident #1 stated that the incident happened a few blocks away from the facility and the local EMS and fire department responded to the incident. Resident #1 stated that the ADM came to the scene of the incident to check on him. Resident #1 stated he didn't remember the date of the incident but stated he believes it happened last month (June 2025).During an interview with the AD on 07/15/2025 at 2:00 PM, The AD stated she was bringing Resident #1 to the facility after he had been discharged from the hospital. The AD stated a few miles away from the facility she had to hit her brakes quickly due to the light turning yellow. The AD stated that Resident #1 slid out his wheelchair onto the floor. The AD stated Resident #1 was buckled when leaving the hospital but at</p>		

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>Based on interviews and record reviews, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered by the state for 1 of 1 Activity Director (AD) reviewed for qualified professionals, in that: Based on interviews and record reviews, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered by the state for 1 of 1 Activity Director (AD) reviewed for qualified professionals, in that: The facility failed to have a qualified AD to serve as the director of the activities program. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident. The findings included: During an interview with the AD on 07/15/2025 at 2:00 PM, The AD stated she has been the AD since March 2025. The AD stated she was an assistant AD/CNA before she was the AD. The AD stated that the previous AD was fired in February 2025, and she has been the AD since. The AD stated that she has been helping as a CNA and transportation driver and hasn't had the time to start her certification. The AD stated that she has enrolled in the appropriate class but could not provide any evidence of her enrollment. During an interview with the ADM on 07/15/2025 at 2:45 PM, the ADM stated that the current AD was previous the AD assistant. The ADM stated that he thought the current AD was enrolled in taking the appropriate classes to have her AD certification. The ADM stated once the appropriate classes were completed then the facility would reimburse the current AD for completing her certification. The ADM stated that he did not have any information that the AD was enrolled in the appropriated classes for her AD certification. The ADM stated a negative outcome would be if the AD did not know the appropriate activity director guidelines due to not completing the AD certification. The ADM stated the facility did not have a policy regarding activities/activities director. Review of the facility Activities Director job description, not dated, reflected must be qualified therapeutic recreation specialist who is: licensed or registered, if applicable by the state in which practicing.</p>		