STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675360	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Springs Nursing Center	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents and hazards.The facility failed to ensure Resident #1 did not elope from the facility through his room window after disabling the alarm and leave through a back gate that was unlatched and walk two blocks to a corner store that's a high crime area at a busy intersection. The noncompliance was identified as PNC (past noncompliance). The Immediate Jeopardy (IJ) began on 02/18/2026 and ended on 02/24/2026. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk for accidents, injuries, and hospitalization that could lead to death. Findings included: Record review of Resident #1's admission record dated 02/27/2026, revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 diagnoses included: unspecified dementia (loss of memory), unspecified mood disorder, and primary hypertension(high blood pressure). Record review of Resident #1's Quarterly MDS assessment, dated 12/02/2025, revealed the resident had a BIMS score of 3 which indicated the resident had severe cognitive impairment.Record review of Resident #1's care plan, dated 02/27/2026, revealed Resident #1 was care planned for impaired cognitive function due to dementia. Resident #1 was care planned for elopement with interventions of redirecting Resident #1 and educating him on the protocol and hazards of leaving the facility. Review of most recent Elopement Risk Assessment dated 10/19/2025, revealed Resident #1 was at risk for elopement due to dementia. Review of elopement incident report dated 02/18/2026 at 7:31 p.m. written by the ADM reflected Resident #1 eloped through the back gate after an argument with POA. Resident #1 was assessed head -to-toe no injuries observed. The incident was reported to the DON, Administrator, Nurse Practitioner, and the family. The staff in the facility was alerted, and the facility was searched. Approximately 20 minutes later, the resident was located in front of the facility carrying a beer. He was escorted back to the facility and placed on one-on-one monitoring. All preventive measures were initiated, including in-service training for the staff. Review of Resident #1's nursing progress note dated 02/18/2026 written by LVN A at 7:00 pm, reflected At approximately 6:45 pm resident at nurse's station yelling and stating he is [AGE] years old, can leave if he wants, and requesting staff to get him a beer. Resident verbalized that he is not in jail and staff cannot keep him in the unit. Attempts were made to verbally redirect residents without success. Resident's POA was notified and spoke with the resident via telephone. During phone conversation, resident became increasingly agitated, yelling at POA, and then returned to his room while continuing to argue. After phone call was conducted, this nurse went to the resident's room to reassess and found resident not present. Bathroom and closet checked, resident not located. Window noted to be closed; however, window screen observed to be pushed back. This nurse immediately proceeded outside the secure unit to search the premises. Secure unit gate found ajar. DON Administrator, and Nurse Practitioner notified immediately of suspected elopement. Approximately 20 minutes later, resident returned to the facility independently carrying a beer and was escorted back to the secure unit by staff without incident. (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
	675360	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Springs Nursing Center	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Head-to-toe assessment completed. No injuries noted. Vital signs obtained and within normal limits. Resident alert and oriented to baseline. Resident stated he just wanted to get a beer. Resident placed on 1:1 monitoring per staff for safety and to prevent further elopement attempts. Staff currently monitoring the resident closely. Will continue to monitor and report any changes in condition or behavior. In an interview with Resident #1 on 02/27/2026 at 9:45 a.m., he stated he could not recall the date and time when he used a butter knife from lunch to take the bolts out his room window to be able to climb out the window and slide under the privacy fence to go the [NAME] store to get a beer. Resident # 1 stated he was bored and thought about going out of the window to the corner store to get a beer because he felt like he was in prison. Resident #1 stated he was not able to go anywhere without staff always monitoring and watching him. Resident # 1 stated after he climbed out the room window he closed the window back down. Resident # 1 stated he learned how to remove bolts from windows from the east side of San [NAME]. Resident # 1 stated he slid his body under the bottom of the fence because he wanted to go to the [NAME] store to get a beer. Resident #1 stated he was not afraid of the neighborhood in his hometown where he went to the [NAME] store to get beer and tacos. Resident # 1 stated he was in his hometown where he was familiar and did not know he was in his hometown Resident #1 stated that the [NAME] store was just a couple of blocks down the street and he was not gone from the facility for no more than 20 minutes. Resident #1 stated when he returned to the facility staff had been looking for him.In an interview with the DON on 02/27/2026 at 11:00 a.m., she stated when the surveyor came in on 02/27/202 the elopement had been corrected. The DON stated received her elopement training with the corporate nurse on 02/18/2026. The DON stated all staff were provided elopement training by 02/24/2026. The DON stated all facility residents elopement assessments were completed on. 02/24/2026. The DON stated care plans were updated, elopement drills completed, and an additional alarm was placed on the secured gate on the secured unit on 02/24/2026. The DON stated all residents on the secured unit along with the other residents' rooms windows were checked. The DON stated the elopement binder was updated on 02/18/2026 to make sure all residents at risk for elopement were in the binder. The DON stated the IDT met on 02/23/2026 and determined to continue 1 to 1 with Resident #1 until the additional alarm was placed on 02/24/2026. In an interview with the Nurse Practitioner on 02/27/2026 at 4:14 p.m., the Nurse Practitioner stated Resident #1 had a BIMS of 3 and was placed on the secured unit for exit seeking. The Nurse Practitioner stated that Resident #1 posed a danger to himself and most likely would get lost due to his dementia if he left the facility unattended.In an interview with the Medical Doctor on 02/27/2026 at 4:40 p.m., the Medical Doctor stated that Resident # 1 was placed on the secured unit for exit seeking behaviors. The Medical Doctor stated that Resident # 1 had a BIMS score of 3 and was not safe leaving the secured unit as Resident #1 was not able to fully understand consequences or actions of what could happen when he had left the facility. The Medical Doctor stated when Resident # 1 went out the window he did not know the consequences of being outside in the dark in an area he was not familiar with. The Medical Doctor stated that Resident was not able to do IDLs which is the lack of function to take care of himself day to day, The Medical Doctor stated Resident # 1 was not able to carry out a normal adult life due to dementia. The Medical Doctor stated that Resident #1's dementia was not getting better and it was not safe for Resident #1 when he left the facility because he could have ended up hurt.In an interview with Maintenance Supervisor on 02/27/2026 at 5:39 p.m., the Maintenance Supervisor stated he was not at the facility when Resident #1 left the facility. The Maintenance Supervisor stated he could not recall the exact date he received a call from the ADM informing him Resident #1 had left the facility. The Maintenance Supervisor stated he searched for Resident #1 along the way to the facility and Resident # 1 retuned around 7:30 pm. The Maintenance Supervisor stated it was determined that the secured unit gate magnet did not latch properly. He stated Fire, safety was called out, and additional alarm was placed on the gate 02/24/2026. The Maintenance Supervisor stated the Maintenance Worker were responsible to make sure the gate was working properly and was expected to check the window and gate alarms daily for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675360	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Springs Nursing Center	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	malfunction. The Maintenance Supervisor stated he received elopement training on 02/19/2026, with the DON over what to do when there was an elopement, making sure all magnets on the gates catch to make sure they are locked, and to make sure windows and gates are checked daily.In an interview with LVN A on 02/27/2026 at 7:07 p.m., LVN A stated she could not recall the exact date last week she called Resident #1 POA because he wanted to leave the facility. She said Resident # 1 stated he was grown and asked why he could not leave the facility. LVN A stated a little before 7:00 pm she called Resident #1's POA by phone to help settle Resident # 1 down. LVN A stated Resident # 1 got more upset and yelled he was [AGE] years old and could leave if he wanted and requested beer. LVN A stated that Resident # 1then got off the phone with his POA shortly after and she was on the phone with Resident #1's POA a couple of minutes after 7:00 pm and then went to Resident # 1's room to check on him and he was not there. LVN A stated she checked Resident #1's room, bathroom, closet, and the window. LVN A stated the window was shut and she was not able to tell the bottom part of the screen was pushed out. LVN A stated she contacted the ADM, DON, Nurse Practitioner that Resident #1was missing, she then went outside, and the secured gate was wide open. LVN A stated she immediately started searching for Resident #1 outside of the facility. LVN A stated Resident # 1 returned to the facility 20 minutes later with a beer in his hand after going to the corner store a couple blocks down the street from the facility. LVN A stated Resident # 1 was placed on 1on 1 supervision until the secured gate was fixed on 02/24/2026. LVN A stated she received elopement training the same night of the elopement on 02/18/2026 with the DON. LVN A stated she was trained on the elopement protocol, what to do in case of elopement, and to make sure all residents are accounted for. An interview with the DON on 02/27/2026 at 7:55 p.m., the DON stated she was not at the facility when Resident #1 went out the secured gate when the latch did not close properly on 02/18/2026 around 7:00 pm. The DON stated it was expected for the maintenance worker to make sure the secured gate latched completely when it was last used around 3:00 pm. The DON stated this could have resulted in harm if Resident #1 had been hit by a car and it was dark outside. The DON stated she completed her elopement training with the corporate nurse on 02/18/2026. The DON stated that the elopement training was over the elopement protocol and what to do when there was an elopement. An interview with the ADM on 02/27/2026 at 8:10 p.m., the ADM stated Resident # 1 went out the secured gate that had a latch malfunction on 02/18/2026 a little before 7:00 pm .The ADM stated that Resident #1 could have experienced a negative outcome with harm if he was injured or did not come back to the facility . The ADM stated it was expected for the maintenance worker to make sure the gate was latched properly when it was last gone out earlier that day on 02/18/2026 around 3:00 pm. The ADM stated all staff elopement training had been completed by survey entrance on 02/27/2026. The ADM stated that corporate nurse completed his training on elopement on 02/18/2026 and the DON completed all staff elopement training on 02/24/2026. The ADM stated the corporate nurse completed in-services over elopement, elopement protocol, time frame to report elopement, search for resident, check windows, and doors.In an interview with Maintenance Worker on 03/02/2026 at 9:45 a.m., the Maintenance worker stated he was expected to make sure the secured outside gate was latched properly once the gate was used earlier that day around 3:00 pm when the funeral home picked up a body. The Maintenance Worker stated the gate was checked and visually appeared to be shut but it was later determined after Resident # 1 left the facility, the secured gate latch mechanism did not lock completely. The Maintenance Worker stated Fire and Safety came out and placed an additional alarm on the gate on 02/24/2026. The Maintenance Worker stated he was expected to check gates, doors, and windows daily. The Maintenance Worker stated not double checking the secured gate, Resident # 1 was able to go through the secured gate and possibly could had been injured or hurt. The Maintenance Worker stated he completed his elopement training on 02/19/2026 with the DON. The Maintenance Worker stated he learned what to do in case of elopement, check the entire facility, check outside the facility, check the neighborhood, check windows, and doors.In an interview with Resident #1's POA on 03/02/2026 at 2:28 p.m., Resident #1's POA stated the evening (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675360	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Springs Nursing Center	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of 02/18/2026 close to 7:00 pm LVN A called her because Resident #1 was upset and wanted to leave the facility to go get a beer. Resident #1's POA stated she did not think Resident #1 would actually leave the facility. Resident # 1's POA stated it was not safe for Resident #1 to have left the facility, he could have been hurt, thank God he came back, he was not familiar with the area he was in. Resident #1's POA stated Resident #1 told her he went out the side gate and went to the store in the neighborhood to get a beer. Resident #1's POA stated that Resident # 1 had dementia but was really smart and told her he felt like he was in jail, he could not go anywhere, and that people were always watching him. Resident #1's POA stated she explained to Resident #1 that he was in the secured unit for his safety after trying to leave the facility on several occasions. Resident #1's POA stated she had to talk to Resident # 1 like a toddler and Resident #1 did have trouble remembering his family members, but remembered things he had done in the past. Resident # 1's POA stated Resident #1 thought he was currently in his hometown and Resident #1 and possibly would not have returned to the facility and that was not safe for Resident #1. Review of the facility's Safety and Supervision of Resident policy, dated 2001, revealed Our facility strives to make the environment as free from accident hazards as possible, Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Policy Interpretation and Implementation Facility Oriented Approach to Safety 1. Our facility-oriented approach to safety addresses risks for groups of residents. Resident Risks and Environmental Hazards1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:e. unsafe wandering.Review of the facility's Wandering and Elopements policy, dated 2001, revised March 2019 revealed The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. This noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 02/18/2026 and ended on 02/24/2026. The facility had corrected the noncompliance before the survey began. The facility took the following actions to correct the non-compliance: - Reviewed Wandering/Elopement Assessments that was conducted on all residents was completed on 02/24/2026.- Reviewed Inservice training on elopement policy, safety, supervision, keeping gates locked, what to do when a resident left the facility, and a team member would check the doors twice per shift was completed on 02/24/2026.- Reviewed Elopement binder that was updated and where the binder was located was completed on 02/24/2026.- Reviewed Care plans updated on all residents that were an elopement risk was completed on 02/24/2026.- Reviewed Assessment on Resident #1, Reviewed Resident #1's updated care plan, 1to 1 supervision was completed on 02/24/2026.- Reviewed QAPI elopement meeting documentation that was completed on 02/19/2026- Reviewed complete elopement incident report on the elopement that was completed on 02/19/2026- Reviewed additional alarm invoice that was placed on the outside secured gate and in good working order was completed on 02/24/2026.- Reviewed POC maintenance would monitor secure unit alarm every shift daily and a blue light flashes and alarm would ring at nurse's station when the gate was opened, and the alarm was triggered was completed on 02/24/2026.- Reviewed POC each resident room that was on the secure unit would be checked each shift to ensure windows and screens was in place completed on 02/18/2026.- Reviewed elopement drill and hands-on staff education that was completed on 02/24/2026.- Reviewed -POC once each shift staff would cross reference the census to physical resident presence was completed on 02/18/2026.- Reviewed Performance Improvement Project that was completed on 02/21/2026.- Reviewed Complete Corrective Action plan that was completed on 02/24/2026.- Reviewed IDT meeting notes it was determined that Resident #1 would continue with 1 to 1 monitoring until the additional alarm was added to the secure unit gate on 02/24/2026. It was also decided that the q 4-hour gate and census checks would also remain in place until the installation of the gate alarm was completed on 02/23/2026.- Reviewed POC all residents' rooms were checked for potential deficient practices. None were noted. No other residents had left the facility, and no one was exit seeking was completed on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675360	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Springs Nursing Center	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	02/18/2026.- Reviewed -POC the lever-style handle that allowed secured gate to open had been removed. The emergency exit button remained unchanged. This emergency button allowed the gate to be opened only in emergencies.- Reviewed POC DON/designee would report any occurrences in morning meeting the following business day x4 weeks or discontinued by IDT was completed on 02/19/2026.-Reviewed POC if there was an issue with a resident that had attempted to leave the building it would be reported to Administrator, DON, ADON, Designee immediately, so interventions could begin was completed on 02/19/2026.