

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  08/31/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795</b></p> <p>Based on observations, interviews and record reviews, the facility failed to ensure the resident had the right to be free from Abuse as defined in this subpart to protect 2 (Resident #42 and Resident #62) of 82 residents from Resident's # 52 aggressive behavior.</p> <ol style="list-style-type: none"> <li>The facility failed to protect the residents from an aggressive resident with behaviors (Resident # 52). Resident #62 sustained an injury to her foot that required her to be taken to the hospital for evaluation.</li> <li>The facility failed to put interventions in place to ensure the safety of Resident # 52 and other residents at the facility.</li> </ol> <p>On 08/30/24 at 6:16 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/31/24, the facility remained out of compliance at a scope of widespread and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure placed the residents at risk for abuse.</p> <p>Findings included:</p> <p>Review of Resident # 42's Quarterly MDS dated [DATE] revealed a [AGE] year-old male admitted to the facility 03/25/2022 with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), stroke (a condition in which poor blood flow to the brain causes cell death) and anxiety disorder (significant and uncontrollable feeling of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired). Resident #42 had a BIMS score of 11 which suggested moderate cognitive impairment.</p> <p>Review of Resident # 62's Quarterly MDS dated [DATE] revealed a [AGE] year-old female admitted to the facility 01-30-2024 with diagnoses that included cerebralvascular accident (a condition in which poor blood flow to the brain causes cell death), anxiety disorder (significant and uncontrollable feeling of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired). Resident #52's BIMS score was 15 which suggested no 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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident # 52's face sheet dated 8/30/2024 revealed a [AGE] year-old male admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (partial paralysis due to a blockage in the brain impeding blood flow), unspecified mood (affective) disorder (any in a group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood), major depressive disorder, recurrent, severe with psychotic symptoms (sadness and hopelessness with symptoms of seeing, hearing, smelling, or believing things that are not real), and intermittent explosive disorder (a condition that causes repeated, sudden outburst of impulsive, violent behavior, or angry verbal outburst).</p> <p>Review of Resident #52's Quarterly MDS dated [DATE], revealed a BIMS score of 08 which indicated a moderate cognitive impairment. Section E0200 Behavioral symptoms revealed no physical behavioral symptoms directed to others, no verbal behavioral symptoms directed toward others, and no other behavioral symptoms not directed toward others.</p> <p>Review of Resident # 52's care plan, dated 04/02/2023 and updated 2/20/2024, revealed Resident # 52's h/o using profanity and verbally aggressive with staff and resident's r/t intermittent explosive disorder. On 04/07/2023 cursed out nurse, 04/19/2023 cursed out resident, 04/20/2020 cursed staff and residents, 05/03/2023 cursed out nurse, 05/20/2023 cursed out nurse and CNA, 06/01/2023 cursed out nurse, 06/08/2023 cursed nurse, 06/09/2023 cursed nurse, 06/11/2023 cursed CNA, 06/12/2023 cursing staff, 06/15/2023 cursed out nurse, 06/20/2023 cursed out nurse, 06/23/2023 cursing in dining room, 07/24/2023 cursed out resident, 07/25/2023 cursed resident out, 08/02/2023 cursing staff, 08/13/2023 cursed out nurse, 08/23/2023 resident in common area, calling female resident a fucking whore, 08/24/2023 residents behavior, unacceptable, cursing, and yelling at nurse, and 08/29/2023 cursing staff and residents: 1/31/2024 verbal aggression initiated, 2/19/2024 verbal aggression initiated.</p> <p>Review of Resident #52's Progress notes dated 8/30/2024 at 11:49 am written by the SW revealed Spoke with the resident regarding incident that happened over the weekend. When SW asked him about it, he responded, 'you don't know?' Resident then stated that he was attacked by the other resident who hit him. He stated he needed to contact his family to let them know that he had been attacked. SW informed him that he has the right to call his family and asked if he needed assistance, he responded no, he can do it. The incident is still under investigation. Several residents were witnesses and state that Resident # 52 was the instigator.</p> <p>Review of Incident and accident report which was not a part of the medical record dated 8/25/2024 at 09:02 am completed by LVN J, At approximately 9 am , once breakfast was completed, this nurse was assessing another resident her breathing treatment when a resident came wheeling down the hall stating, they are fighting. I did not immediately understand what was going on, then I realized everyone was moving towards the dining hall and I followed. Once I arrived in the dining hall the residents were being separated. I spoke and found a housekeeper who had witnessed most of the incident, Resident # 52 was verbally, harassing Resident #42, Resident # 42 told him something around the lines of leave me alone I'm not bothering you or anyone. Resident #52 preceded to go around the wall towards Resident #42 and continued to verbally harass him then threw something towards Resident #42's direction. Resident #42 then picked up a chair to hit Resident # 52 and staff members removed the chair from Resident # 42's hands, then Resident #42 attempted to hit Resident #52. Due to a lot of bodies and movement it is unsure if Resident #42 actually hit Resident #52.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on 8/27/2024 at 10:00 am with Resident # 52 he stated he did not wish to answer questions at that time.</p> <p>In an interview on 8/27/2024 at 10:30 am with Resident #42, he stated that Resident #52 always picked on him and this last weekend he pushed to far and he felt he had to do something . He did not share details of the other incidents but stated that the administrator and other staff were aware of the situation.</p> <p>In an interview on 8/27/2024 at 11 am with Resident #62, she reported that when Resident #52 threw a bowl this weekend, it hit her foot. There was a bruise, swelling, and pain. She was sent to the Emergency R room that afternoon for evaluation. The doctor will follow up with her today about the foot as she was still in pain . The resident stated this happened on Saturday and several staff member were present, she stated that this is an ongoing issue but did not elaborate for the other incidents.</p> <p>During the Resident council meeting on 8/28/224 at 10 am revealed many of the residents stated there was a resident in the facility that is verbally and aggressive behavior (Resident # 52), resident report the facility is aware of the behaviors and do not appear to be doing anything about it. Several residents stated that there were afraid of (resident #52 because of his aggressive behaviors) , one resident stated he now carries a cane with him when he leaves his room so that he can protect himself from (Resident #52).</p> <p>In an interview on 8/29/2024 at 11 am with the DON, she stated that she was aware of the incident and did not know if it was reported to the state, as the administrator was the one that was responsible for that. She was not sure if it would qualify as reportable or not. She stated all they could do was redirect Resident # 52 when he got upset to help keep the other residents safe in the dining room. The DON stated an incident report was completed and the incident was not part of the medical record. She stated they were actively seeking placement for the resident and were having placement issues with Resident # 52 because of the behaviors .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on 8/29/2024 at 11:30 with the ADM, he stated that he looked into the resident-to-resident altercation and felt that there was no intent for the bystander resident to be harmed so he did not report it. The ADM stated he was notified on Saturday of the event and did his investigation on Monday. He stated he was aware of the 24 hours requirement to report abuse which resident to resident altercation is considered. He acknowledged that and was not sure what he needed to report. He stated the injury to Resident # 62 by Resident # 52 was an accident and not intentional, he stated from the staff report over the phone to him on Saturday he determined that the injury was unintentional and did not do an investigation till Monday. The ADM stated Resident #52 was a difficult case, and that he never should have been admitted to the facility. He stated the more they document Resident #52's behaviors the more difficult placement will be. He stated he was afraid to put him on a one to one because that could set him off and may result in him getting physical. The ADM stated he is not really is not sure what to do, until they get him accepted at another facility. He stated his expectation that the staff keep them and the other resident's safe from Resident # 52's behaviors. The ADM stated Resident #52 's behavior did place the residents and staff at risk for abuse. He stated Resident #52 was difficult to deal with and they had been seeking placement for Resident # 52 in a more appropriate facility but had not found a placement yet that would accept him with his behaviors. The ADM stated there were no special interventions in place at this time for his behaviors.</p> <p>In an interview on 8/29/2024 at 11:45 am with the SW, she stated that she was trying very hard to get Resident # 52 to a different facility. SW stated she is aware of the concerns of the other resident with the behaviors of Resident # 52, She stated that her interventions with Resident # 52 are to discuss the behavior with him and try to redirect it., she admitted that most times this is not successful. She stated Resident # 52 is not currently on any kind of behavior modification plan and the psychiatric NP sees him, and the local authority follows. him with services. She stated there is a policy for dealing with aggressive residents but she does not use the interventions with Resident # 52 and he is not responsive to it, Her goal for Resident # 52 is to keep him and the other residents safe until placement can be found.</p> <p>Review of Tulip 8/29/2024 at noon revealed no reported incident from the 8/26/2024 or 8/27/2024.</p> <p>Review of the facility policy Abuse Prevention Program revised December of 2016 stated As part of the abuse prevention, the administration will 1. Protect our resident from abuse by anyone including but not necessarily limited to facility, staff, other residents.</p> <p>Review of the facility policy Resident to Resident Altercations/aggressive behavior Revised September 2022 Facility staff should monitor resident for aggressive behavior, instance of behavior should be reported immediately .If you are unable to prevent an aggressive behavior or altercation, your priority is to ensure the safety of yourself and anyone around.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on [8/30/2024 at 5:25 PM The ADM] were notified. The ADM] was provide with the IJ template on [8/30/2024 at 5:25 PM].</p> <p>The following Plan of Removal submitted by the facility was accepted on 08/31/24 at 12:35 PM and reflected the following:</p> <p>The alleged deficient practice was the facility failed to protect the residents from an aggressive resident with behaviors and failed to put interventions in place to ensure the safety of the resident and other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Identification of Residents Affected or Likely to be Affected:</p> <p>The following actions were taken to prevent Resident # 52 from perpetrating additional abusive behaviors. (Completion Date: 8/30/2024)</p> <p>The Medical director was notified of the current IJ at the facility.</p> <p>Resident # 52 was admitted to hospital on 8/30/24.</p> <p>admitted via emergency detention order on 8/30/24.</p> <p>2. Actions to Prevent Occurrence/Recurrence:</p> <p>The facility took the following actions to prevent an adverse outcome from reoccurring.</p> <p>Abuse policies were reviewed/updated on 8/30/24.</p> <p>The Administrator/designee re-educated all staff on facility abuse policies. This will be completed by 8/31/24.</p> <p>The administrator/DON were provided re-education from the corporate nurse and COO on 8/30/24 7:30 PM.</p> <p>All residents were reviewed by the SW and marketing director with no aggressive behaviors found at this time. 8/31/24 11:30 am.</p> <p>The administrator/designee provided re-education to all staff on abuse prevention and reporting.</p> <p>The DON and designee educated Nurse Aides and Licensed Nurses on documenting behaviors. Behavior documentation will be monitored by the Social Services Director or designee and care plans will be updated as indicated. Staff will be educated on new interventions either verbally or in written form by the Care Plan Coordinator or designee.</p> <p>In the event of any future resident to resident abuse, the perpetrating resident will immediately be placed on 1:1 supervision until primary care, nursing, and psychiatric evaluations can be complete. Outcomes of these evaluations will result in continued 1:1 supervision or the initiation of discharge planning to a facility with a focus on behavior management.</p> <p>New staff will be educated and trained on facility abuse policies upon hire during general orientation.</p> <p>Agency staff will be educated and trained on facility abuse policies prior to starting shift.</p> <p>Abuse Prevention and Response policies made available for review at all times.</p> <p>Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 8/31/24.</p> <p>Monitoring of facility's Plan of Removal included the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Audit of Policies : Abuse and Neglect, Reporting, care plans and documentation to show they were reviewed by the corporate nurse and the administrative team were educated on 8/30/2024.</p> <p>2. In-services to Staff on Abuse and Neglect were started on 8/30/24 and per audit completed at 2:30 PM on 8/31/2024 all staff scheduled from 8/30/2024 thru 8/31/2024 have completed the training. All administrative staff completed the training, plan was for remaining staff and PRNs to complete training prior to working the next shift. A text was sent out to all employees with expectations.</p> <p>3. In-services to Nursing staff and IDT team on Care plans and documentation were started on 8/30/2024 and per audit on 8/31/2024, all nursing staff on duty and all IDT team members have completed training. The plan was for the remaining staff and PRNs to complete training prior to working the next shift. A text was sent out to all employees with expectations.</p> <p>4. Per interview with administrator, 1:1's will be determined by himself, and the DON and in-services will be done at that time to address the residents needs.</p> <p>5. Interviews with 9/18 staff members on duty 8/30 /2024 and on 8/31/2024 in the day and evening shift revealed they have all had training and all were able to verbalize the training and the process for reporting and managing resident to resident aggression .</p> <p>The ADM was informed the Immediate Jeopardy (IJ) was removed on 8/31/2024 at 5:45 PM ). The facility remained out of compliance at a scope of widespread and a severity level of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795</b></p> <p>Based on interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of resident's, establish policies and procedures to investigate any such allegations for 3 out of 16 residents reviewed for abuse.</p> <p>The facility failed to follow and implement its policy regarding Resident # 52's verbal and physical abuse of other residents to ensure the safety of all residents .</p> <p>An IJ was identified on 08/30/24. The IJ template was provided to the facility on [DATE] at 6:16 PM. While the IJ was removed on 08/31/24, the facility remained out of compliance at a scope of widespread and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal.</p> <p>This failure could put all residents at risk from abuse.</p> <p>Finding include:</p> <p>Review of Resident # 52's face sheet dated 8/30/2024 revealed a [AGE] year-old male admitted on [DATE] with diagnosis that include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, ( partial paralysis due to a blockage in the brain impeding blood flow), Unspecified mood ( Affective) disorder ( any in a group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood) Major depressive disorder, recurrent, severe with psychotic symptoms (sadness and hopelessness with symptoms of seeing, hearing, smelling or believing things that are not real) and Intermittent Explosive Disorder ( a condition that causes repeated, sudden outburst of impulsive, violent behavior or angry verbal outburst).</p> <p>Review of Resident #52's Quarterly MDS dated [DATE], revealed a BIMS score of 08 (indicates a Moderate cognitive impairment) Section E0200 Behavioral symptoms revealed no physical behavioral symptoms directed to others, no verbal behavioral symptoms directed toward others, and no other behavioral symptoms not directed toward others.</p> <p>Review of Residents # 52 care plan 04/02/2023 and updated 2/20/2024 revealed Resident #52's h/o using profanity/verbally.</p> <p>aggressive with staff and resident's r/t intermittent explosive disorder.</p> <p>04/07/2023 Cursed out nurse,04/19/2023 Cursed out resident,04/20/2020 cursed staff and residents, 05/03/2023 Cursed out nurse,05/20/2023 Cursed out nurse and CNA, 06/01/2023 Cursed out nurse, 06/08/2023 cursed nurse,06/09/2023 cursed nurse,06/11/2023 Cursed CAN,06/12/2023 Cursing staff, 06/15/2023 Cursed out nurse,06/20/2023 Cursed out nurse,06/23/2023 cursing in dining room,07/24/2023 curses out resident,07/25/2023 cursed resident out,08/02/2023 cursing staff,08/13/2023 cursed out nurse, 08/23/2023 Resident in common area, calling female resident a fucking whore,08/24/2023 Residents behavior, unacceptable, cursing and yelling at nurse and,08/29/203 cursing staff and residents,1/31/2024 verbal aggression initiated,2/19/2024 verbal aggression initiated</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident's #52 Process notes dated 8/30/2024 at 11.49 am written by the SW revealed Spoke with the resident regarding incident that happened over the weekend. When SW asked him about it, he responded, you don't 'Know?' Resident then stated that he was attacked by the other resident who hit him. He stated he needed to contact his family to let them know that he had been attacked. SW informed him that he has the right to call his family and asked if he needed assistance, he responded no, he can do it. The incident is still under investigation. Several residents were witnesses and state that Resident # 52 was the instigator.</p> <p>Review of Incident and accident report which is not a part of the medical record dated 8/25/2024 09:02 am completed by LVN J,</p> <p>At approximately 0 am, once breakfast was completed, this nurse was assessing another resident her breathing treatment when a resident came wheeling down the hall stating, they are fighting. I did not immediately understand what was going on, then I realized everyone was moving towards the dining hall and I followed. Once I arrived in the dining hall resident where being separated. I spoke and found a housekeeper who had witnessed most of the incident, Resident # 52 was verbally, harassing Resident #42, Resident # 42 told him something around the lines of leave me alone I'm not bothering you or anyone, Resident #52 preceded to go around the wall towards Resident #42 and continued to verbally harass him then threw something towards Resident #42's direction. Resident #42 then picked up a chair to hit Resident # 52 and staff members removed the chair from Resident # 42's hands, then Resident #42 attempted to hit Resident #52. Due to a lot of bodies and movement it is unsure if Resident #42 actually hit Resident #52.</p> <p>Review of Resident # 42 Quarterly MDS dated [DATE] revealed a [AGE] year-old male admitted to the facility 03/25/2022 with diagnosis that include Alzheimer's disease ( A progressive disease that destroys memory and other important mental functions), Stroke ( a condition in which poor blood flow to the brain causes cell death) and Anxiety disorder (significant and uncontrollable feeling of anxiety and fear such that a person's social, occupational and personal functions are significantly impaired). BIMS score of 11 (8-12 suggests moderate cognitive impairment)</p> <p>Review of Resident # 62 Quarterly MDS dated [DATE] revealed a [AGE] year-old female admitted to the facility 01-30-2024 with diagnosis that include Cardiovascular Accident ( a condition in which poor blood flow to the brain causes cell death) Anxiety disorder (significant and uncontrollable feeling of anxiety and fear such that a person's social, occupational and personal functions are significantly impaired).BIMS score of 15 ( 13-15 suggest no cognitive impairment)</p> <p>Interview 8/27/2024 at 10:00 am with Resident # 52 he does not wish to answer questions at this time.</p> <p>Interview 8/27/2024 at 10:30 am with Resident #42, he stated that Resident #52 always picks on him and this last weekend he pushed too far, and he felt he had to do something.</p> <p>Interview 8/27/2024 at 11 am with Resident #62 reported that when Resident #52 threw a bowl this weekend, it hit her foot and there was a bruise, swelling and pain, she was sent to the ER that afternoon for evaluation, the doctor will follow up with he today about the foot as she is still in pain.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During the Resident council meeting on 8/28/224 at 10 am revealed many of the residents stated there was a resident in the facility that is verbally and aggressive behavior (Resident # 52), resident report the facility is aware of the behaviors and do not appear to be doing anything about it. Several residents stated that there were afraid of (resident #52 because of his aggressive behaviors) , one resident stated he now carries a cane with him when he leaves his room so that he can protect himself from (Resident #52).</p> <p>Interview 8/29/2024 at 11 am with the DON, she stated that she was aware of the incident and does not know if it was reported to the state, as the administrator is the one that is responsible for that. she is not sure if it would qualify as reportable or not. she stated all we can do is redirect Resident # 52 when he gets upset, Staff are to monitor Resident # 52 when in common area's to assist in this to keep the others residents safe. They do have a policy for aggressive residents, Resident's #52 is resistance to any interventions. She stated her expectation is that all resident's incident should be reflected in the Resident's progress notes.</p> <p>Interview 8/29/2024 at 11:30 with ADN He stated that he looked into the resident-to-resident altercation and feel that there was no intent for the bystander resident to be harmed so he did not report it. ADN stated he was notified on Saturday by phone of the incident with Resident # 52 did his investigation on Monday He stated the facility policy it that resident to resident are to be reported within 24 hours, he stated that he determined the injury to Resident # 62 foot was not intention and did not meet the reporting requirement.</p> <p>Interview 8/29/2024 at 11:45 am with SW, she stated that she is trying very hard to get Resident #52 to a different facility. She stated that the Facility does have a policy for Resident-to-Resident altercations that include separating the residents involved, and they do that with Resident #52. She does not know how many incidents with Resident's #52's behavior there are but she thinks at the minimum he is verbally aggressive two to three times a week.</p> <p>Review of Tulip 8/29/2024 at noon revealed no reported incident from the 8/26/2024 or 8/27/2024.</p> <p>Review of facility policy 8/29/2024 at 12:30 PM Resident to Resident Altercations/aggressive behavior Revised September 2022 Facility staff should monitor resident for aggressive behavior, instance of behavior should be reported immediately .If you are unable to prevent an aggressive behavior or altercation, your priority is to ensure the safety of yourself and anyone around.</p> <p>The facility's Plan of Removal for the Immediate Jeopardy was accepted on 08/31/24 at 12:35 PM and reflected the following:</p> <p>The alleged deficient practice was the facility failed to follow and implement a policy regarding verbal and physical abuse of other residents and ensure the safety of other residents.</p> <p>3. Identification of Residents Affected or Likely to be Affected:</p> <p>The facility took the following actions to address the citation and prevent any additional residents from suffering's an adverse outcome. (Completion Date: by. 8/30/24)</p> <p>(continued on next page)</p>		

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  08/31/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Administrator or designee immediately ensured the safety and well-being of all residents.</p> <p>Resident #52 was sent to psych hospital for inpatient stay by an emergency detention warrant obtained through the county judges office on 8/30/24.</p> <p>4. Actions to Prevent Occurrence/Recurrence:</p> <p>The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 8/30/24)</p> <p>Resident #52 was taken to psych hospital on 8/30/24, Oceans hospital.</p> <p>Abuse policies were reviewed 8/30/24 by both corporate nurses at 6:30 PM</p> <p>The Administrator and DON were re-in serviced by the corporate nurse and COO on 8/30/24 at 7:30 PM.</p> <p>All residents were reviewed by the SS and marketing director, and no one is exhibiting aggressive behaviors at this time on 8/31/24 at 11:30 am.</p> <p>Abuse investigation procedure and documentation process were reviewed 8/30/24 by both corporate nurses at 6:30pm.</p> <p>The administrator and designees educated all staff on facility abuse policies. Started on 8/30/24 and will be completed by 8/31/24.</p> <p>The administrator and designees educated all staff on abuse prevention and reporting, started on 8/30/24 and will be completed by 8/31/24.</p> <p>The Social Services Director began discussing facility abuse policies with residents and families at the initial care plan conference for all new residents that enter the facility.</p> <p>New staff will be educated and trained on facility abuse policies upon hire during general orientation.</p> <p>Agency staff will be educated and trained on facility abuse policies prior to starting shift.</p> <p>Abuse Prevention and Response policies made available for review at all times.</p> <p>Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 8/31/24.</p> <p>The alleged deficient practice is the facility failed to protect the residents from an aggressive with behaviors and failed to put interventions in place to ensure the safety of the resident and other residents.</p> <p>Monitoring of facility's Plan of Removal included the following:</p> <p>1. Confirmation that Resident was discharged on [DATE] to Ocean' behavioral hospital.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. Audit of Policies to show they were reviewed by the corporate nurse and the administrative team were educated on 8/30/2024.</p> <p>3. In-services to Staff on Abuse Neglect were started on 8/30/24 and per audit completed at 2:30 PM on 8/31/2024 all staff scheduled from 8/30/2024 thru 8/31/2024 have completed the training. All administrative staff completed the training, plan is for remaining staff and PRNs to complete training prior to working the next shift. A text was sent out to all employees with expectations.</p> <p>4. In-services to Nursing staff and IDT team on Care plans and documentation were started on 8/30/2024 and per audit on 8/31/2024, all nursing staff on duty and all IDT team members have completed training, Plan is for remaining staff and PRNs to complete training prior to working the next shift. A text was sent out to all employees with expectations.</p> <p>5. Per interview with administrator, 1:1's will be determined by himself and the DON and in services will be done at that time to address the resident's needs.</p> <p>6. Interviews with 9/18 staff members on duty 8/31/2024 revealed they have all had training and all were able to verbalize the training and the process for reporting and managing resident to resident aggression.</p> <p>An IJ was identified on 08/30/24. The IJ template was provided to the facility on [DATE] at 6:16 PM. While the IJ was removed on 08/31/24, the facility remained out of compliance at a scope of widespread and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal.</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>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** 47795</b></p> <p>Based on interviews and record review, the facility failed to ensure all alleged violations involving Resident to Resident altercations were reported immediately to the administrator or the abuse coordinator and to THHSC within the 2-hour period for 1 of 2 residents (Resident #52 and Resident # 42) reviewed for abuse.</p> <p>The facility failed to ensure allegations of resident abuse with injury were immediately reported to the administrator or abuse coordinator and to the State Agency no later than 2 hours after the incident occurred or was suspected.</p> <p>This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>Review of Resident # 52's face sheet dated 8/30/2024 revealed a [AGE] year-old male admitted on [DATE] with diagnosis that include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, ( partial paralysis due to a blockage in the brain impeding blood flow), Unspecified mood ( Affective) disorder ( any in a group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood) Major depressive disorder, recurrent, severe with psychotic symptoms (sadness and hopelessness with symptoms of seeing, hearing, smelling or believing things that are not real) and Intermittent Explosive Disorder ( a condition that causes repeated, sudden outburst of impulsive, violent behavior or angry verbal outburst).</p> <p>Review of Resident #52's Quarterly MDS dated [DATE], revealed a BIMS score of 08 (indicates a Moderate cognitive impairment) Section E0200 Behavioral symptoms revealed no physical behavioral symptoms directed to others, no verbal behavioral symptoms directed toward others, and no other behavioral symptoms not directed toward others.</p> <p>Review of Residents # 52 care plan 04/02/2023 and updated 2/20/2024 revealed Resident #52's h/o using profanity/verbally.</p> <p>aggressive with staff and resident's r/t intermittent explosive disorder.</p> <p>04/07/2023 Cursed out nurse,04/19/2023 Cursed out resident,04/20/2020 cursed staff and residents, 05/03/2023 Cursed out nurse,05/20/2023 Cursed out nurse and CNA, 06/01/2023 Cursed out nurse, 06/08/2023 cursed nurse,06/09/2023 cursed nurse,06/11/2023 Cursed CNA,06/12/2023 Cursing staff, 06/15/2023 Cursed out nurse,06/20/2023 Cursed out nurse,06/23/2023 cursing in dining room,07/24/2023 cures out resident,07/25/2023 cursed resident out,08/02/2023 cursing staff,08/13/2023 cursed out nurse, 08/23/2023 Resident in common area, calling female resident a fucking whore,08/24/2023 Residents behavior, unacceptable, cursing and yelling at nurse and,08/29/203 cursing staff and residents,1/31/2024 verbal aggression initiated,2/19/2024 verbal aggression initiated</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 Resident's #52 Process notes dated 8/30/2024 at 11.49 am written by the SW revealed Spoke with the resident regarding incident that happened over the weekend. When SW asked him about it, he responded, you don't 'Know?' Resident then stated that he was attacked by the other resident who hit him. He stated he needed to contact his family to let them know that he had been attacked. SW informed him that he has the right to call his family and asked if he needed assistance, he responded no, he can do it. The incident is still under investigation. Several residents were witnesses and state that Resident # 52 was the instigator.</p> <p>Review of Incident and accident report which is not a part of the medical record dated 8/25/2024 09:02 am completed by LVN J,</p> <p>At approximately 0 am, once breakfast was completed, this nurse was assessing another resident her breathing treatment when a resident came wheeling down the hall stating, they are fighting. I did not immediately understand what was going on, then I realized everyone was moving towards the dining hall and I followed. Once I arrived in the dining hall resident where being separated. I spoke and found a housekeeper who had witnessed most of the incident, Resident # 52 was verbally, harassing Resident #42, Resident # 42 told him something around the lines of leave me alone I'm not bothering you or anyone, Resident #52 preceded to go around the wall towards Resident #42 and continued to verbally harass him then threw something towards Resident #42's direction. Resident #42 then picked up a chair to hit Resident # 52 and staff members removed the chair from Resident # 42's hands, then Resident #42 attempted to hit Resident #52. Due to a lot of bodies and movement it is unsure if Resident #42 actually hit Resident #52. Per the report the administrator, responsible party and primary medical doctor were notified.</p> <p>Review of Resident # 42 Quarterly MDS dated [DATE] revealed a [AGE] year-old male admitted to the facility 03/25/2022 with diagnosis that include Alzheimer's disease ( A progressive disease that destroys memory and other important mental functions), Stroke ( a condition in which poor blood flow to the brain causes cell death) and Anxiety disorder (significant and uncontrollable feeling of anxiety and fear such that a person's social, occupational and personal functions are significantly impaired). BIMS score of 11 (8-12 suggests moderate cognitive impairment)</p> <p>Interview 8/27/2024 at 10:00 am with Resident # 52 he does not wish to answer questions at this time.</p> <p>Interview 8/27/2024 at 10:30 am with Resident #42, he stated that Resident #52 always picks on him and this last weekend he pushed too far, and he felt he had to do something.</p> <p>Interview 8/29/2024 at 11 am with the DON, she stated that she was aware of the incident and does not know if it was reported to the state, as the administrator is the one that is responsible for that. she is not sure if it would.</p> <p>qualify as reportable or not. Her expectation is that all staff report and incident with suspicion of abuse to the ADM at the time of the occurrence.</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 8/29/2024 at 11:30 with ADM He stated that he investigated the resident-to-resident altercation with Resident # 52 and the injury of Resident # 62 and feel that there was no intent for the bystander resident to be harmed so he did not report it. ADM stated he was notified on Saturday by staff over the telephone of the event and did his investigation on Monday. He stated that his understanding that for abuse to be reported intent must be present. ADM what not sure what the facility policy stated about the time line to report, but he was aware of the state requirement.</p> <p>Review of Tulip 8/29/2024 at noon revealed no reported incident from the 8/26/2024 or 8/27/2024.</p> <p>Review of the facility policy Abuse Prevention Program revised December of 2016 stated As part of the abuse prevention, the administration will 1. Protect our resident from abuse by anyone including but not necessarily limited to facility, staff, other residents. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin will be reported by the facility administrator, or his/her designee to the following persons or agencies.</p> <ul style="list-style-type: none"> <li>a. The state licensing agency responsible for surveying/licensing the facility</li> <li>b. The local/state ombudsman</li> <li>c. The resident's representative of record</li> <li>d. Law enforcement officials</li> <li>e. The resident's attending physician</li> <li>f. The facility medical director</li> </ul> <p>Review of the facility policy Resident to Resident Altercations/aggressive behavior Revised September 2022 Facility staff should monitor resident for aggressive behavior, instance of behavior should be reported immediately .If you are unable to prevent an aggressive behavior or altercation, your priority is to ensure the safety of yourself and anyone around.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795</b></p> <p>Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment . For 1 (Resident # 52) of 16 reviewed.</p> <p>The facility failed to develop and implement a comprehensive care plan for Resident # 52 that included interventions to ensure safety from the residents aggressive physical and verbal behaviors.</p> <p>On 08/30/24 at 6:16 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/31/24, the facility remained out of compliance at a scope of widespread and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure put the resident at risk from their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>Review of Resident # 52's face sheet dated 8/30/2024 revealed a [AGE] year-old male admitted on [DATE] with diagnosis that include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, ( partial paralysis due to a blockage in the brain impeding blood flow), Unspecified mood ( Affective) disorder ( any in a group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood) Major depressive disorder, recurrent, severe with psychotic symptoms (sadness and hopelessness with symptoms of seeing, hearing, smelling or believing things that are not real) and Intermittent Explosive Disorder ( a condition that causes repeated, sudden outburst of impulsive, violent behavior or angry verbal outburst).</p> <p>Review of Resident #52's Quarterly MDS dated [DATE], revealed a BIMS score of 08 (indicates a Moderate cognitive impairment) Section E0200 Behavioral symptoms revealed no physical behavioral symptoms directed to others, no verbal behavioral symptoms directed toward others, and no other behavioral symptoms not directed toward others.</p> <p>Review of Residents # 52 care plan 04/02/2023 and updated 2/20/2024 revealed Resident #52's h/o using profanity/verbally aggressive with staff and resident's r/t intermittent explosive disorder.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>04/07/2023 Cursed out nurse,04/19/2023 Cursed out resident,04/20/2020 cursed staff and residents, 05/03/2023 Cursed out nurse,05/20/2023 Cursed out nurse and CNA, 06/01/2023 Cursed out nurse, 06/08/2023 cursed nurse,06/09/2023 cursed nurse,06/11/2023 Cursed CNA,06/12/2023 Cursing staff, 06/15/2023 Cursed out nurse,06/20/2023 Cursed out nurse,06/23/2023 cursing in dining room,07/24/2023 cures out resident,07/25/2023 cursed resident out,08/02/2023 cursing staff,08/13/2023 cursed out nurse, 08/23/2023 Resident in common area, calling female resident a fucking whore,08/24/2023 Residents behavior, unacceptable, cursing and yelling at nurse and,08/29/203 cursing staff and residents,1/31/2024 verbal aggression initiated,2/19/2024 verbal aggression initiated</p> <p>Review of Resident's #52 Process notes dated 8/30/2024 at 11.49 am written by the SW revealed Spoke with the resident regarding incident that happened over the weekend. When SW asked him about it, he responded, you don't 'Know?' Resident then stated that he was attacked by the other resident who hit him. He stated he needed to contact his family to let them know that he had been attacked. SW informed him that he has the right to call his family and asked if he needed assistance, he responded no, he can do it. The incident is still under investigation. Several residents were witnesses and state that Resident # 52 was the instigator.</p> <p>Review of Incident and accident report which is not a part of the medical record dated 8/25/2024 09:02 am completed by LVN J, At approximately 0 am, once breakfast was completed, this nurse was assessing another resident her breathing treatment when a resident came wheeling down the hall stating, they are fighting. I did not immediately understand what was going on, then I realized everyone was moving towards the dining hall and I followed. Once I arrived in the dining hall resident where being separated. I spoke and found a housekeeper who had witnessed most of the incident, Resident # 52 was verbally, harassing Resident #42, Resident # 42 told him something around the lines of leave me alone I'm not bothering you or anyone, Resident #52 preceded to go around the wall towards Resident #42 and continued to verbally harass him then threw something towards Resident #42's direction. Resident #42 then picked up a chair to hit Resident # 52 and staff members removed the chair from Resident # 42's hands, then Resident #42 attempted to hit Resident #52. Due to a lot of bodies and movement it is unsure if Resident #42 actually hit Resident #52.</p> <p>During the Resident council meeting on 8/28/224 at 10 am revealed many of the residents stated there was a resident in the facility that is verbally and aggressive behavior (Resident # 52), resident report the facility is aware of the behaviors and do not appear to be doing anything about it. Several residents stated that there were afraid of (resident #52 because of his aggressive behaviors) , one resident stated he now carries a cane with him when he leaves his room so that he can protect himself from (Resident #52).</p> <p>In an interview on 8/29/2024 at 11:45 am with the SW, she stated that she was trying very hard to get Resident # 52 to a different facility. SW stated she is aware of the concerns of the other resident with the behaviors of Resident # 52, She stated that her interventions with Resident # 52 are to discuss the behavior with him and try to redirect it., she admitted that most times this is not successful. She stated Resident # 52 is not currently on any kind of behavior modification plan and the psychiatric NP sees him, and the local authority follows. him with services. She stated there is a policy for dealing with aggressive residents but the she does not use the interventions with Resident # 52 and he is not responsive to it, her goal for Resident # 52 is to keep him and the other residents safe until placement can be found.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 8/29/2024 at 11:30 with the ADN, he stated that he looked into the resident-to-resident altercation and felt that there was no intent for the bystander resident to be harmed so he did not report it. The ADN stated he was notified on Saturday of the event and did his investigation on Monday. He stated he was aware of the 24 hours requirement to report abuse which resident to resident altercation is considered. He acknowledged that and was not sure what he needed to report. He stated the injury to Resident # 62 by Resident # 52 was an accident and not intentional, he stated from the staff report over the phone to him on Saturday he determined that the injury was unintentional and did not do an investigation till Monday. The ADN stated Resident #52 was a difficult case, and that he never should have been admitted to the facility. He stated the more they document Resident #52's behaviors the more difficult placement will be. He stated he was afraid to put him on a one to one because that could set him off and may result in him getting physical. The ADN stated he is not really is not sure what to do, until they get him accepted at another facility. He stated his expectation that the staff keep them and the other resident's safe from Resident # 52's behaviors. The ADN stated Resident #52 's behavior did place the residents and staff at risk for abuse. He stated Resident #52 was difficult to deal with and they had been seeking placement for Resident # 52 in a more appropriate facility but had not found a placement yet that would accept him with his behaviors. The ADN stated there were no special interventions in place at this time for his behaviors.</p> <p>Review of Policy Care Plans, comprehensive Person-centered revised December 2016 on 8/30/2024 at 1:30 PM revealed The comprehensive, person-centered care plan will be. Describe the services that are to be furnished to attain or maintain the resident highest practicable physical, mental and psychosocial well-being.</p> <p>This was determined to be an Immediate Jeopardy (I) on [Date] at [Time]. The [identifier of people notified] were notified. The [identifier of the person given the I template ] was provide with the IJ template on [Date] at [Time].</p> <p>The following Plan of Removal submitted by the facility was accepted on 08/31/24 at 12:35 PM and reflected the following:</p> <p>The alleged deficient practice was the facility failed to develop and implement a comprehensive care plan that included interventions to ensure safety from the residents aggressive, physical, and verbal behaviors.</p> <p>1. Identification of Residents Affected or Likely to be Affected:</p> <p>The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 8/30/24)</p> <p>This Resident was discharged on [DATE] with no plan to return to the facility. The facility issued an emergency discharge to ensure the safety of other residents.</p> <p>2. Actions to Prevent Occurrence/Recurrence:</p> <p>The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 8/31/24)</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Every incident should result in a revision of the care plan to prevent recurrence of any altercation.</p> <p>All residents were reviewed by the SS and marketing director with no one exhibiting aggressive behaviors at this time of 8/31/24 @ 11:30 am.</p> <p>The IDT team will be in-serviced on the care plan revision policy and process by the corporate nurse/DON by 8/31/24.</p> <p>The DON or designee will audit each care plan after each incident to ensure interventions were in place to protect the well-being of other residents as appropriate. In-serviced by corporate nurses at 8:00 PM on 8/30/24.</p> <p>A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP ) was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAA meeting for a minimum of three months or until the pattern of compliance is maintained. QAPI will be completed by corporate nurse by 8/30/24.</p> <p>New staff will be educated and trained on facility abuse policies upon hire during general orientation.</p> <p>Agency staff will be educated and trained on facility abuse policies prior to starting shift.</p> <p>Abuse Prevention and Response policies made available for review at all times.</p> <p>Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 8/31/24.</p> <p>Monitoring of facility's Plan of Removal included the following:</p> <ol style="list-style-type: none"> <li>3. Confirmation that Resident # 52's was discharged on [DATE] to behavioral hospital.</li> <li>4. Audit of Policies to show they were reviewed by the corporate nurse and the administrative team were educated on 8/30/2024.</li> <li>5. In-services to Staff on Abuse and Neglect were started on 8/30/24 and per audit completed at 2:30 PM on 8/31/2024 all staff scheduled from 8/30/2024 thru 8/31/2024 have completed the training. All administrative staff completed the training, plan is for remaining staff and PRNs to complete training prior to working the next shift. A text was sent out to all employees with expectations.</li> <li>6. In-services to Nursing staff and IDT team on Care plans and documentation were started on 8/30/2024 and per audit on 8/31/2024, all nursing staff on duty and all IDT team members have completed training, Plan is for remaining staff and PRNs to complete training prior to working the next shift. A text was sent out to all employees with expectations.</li> <li>7. Per interview with administrator, 1:1's will be determined by himself and the DON and in services will be done at that time to address the resident's needs.</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Woodland Springs Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 Dallas St Waco, TX 76704	

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>8. Interviews with 9/18 staff members on duty 8/31/2024 revealed they have all had training and all were able to verbalize the training and the process for reporting and managing resident to resident aggression.</p> <p>An IJ was identified on 08/30/24 at 6:16 PM . The IJ template was provided to the facility on [DATE] at 6:16 PM. While the IJ was removed on 08/31/24, the facility remained out of compliance at a scope of Isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45070</p> <p>Based on interviews and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for three (Resident #45, Resident #25, and Resident #10) of six residents reviewed for pharmaceutical services., in that:</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. Resident #45 was administered his prescribed Diltiazem (for hypertension), Gabapentin (for neuropathy), and Amiodarone (for arrhythmia).</li> <li>2. Resident #25 was administered his prescribed Hydroxyzine Pamoate and Gabapentin (for bipolar disorder), Abilify and Benztropine Mesylate (for Schizophrenia), and Divalproex Sodium ER (for agitation).</li> <li>3. Resident #10 was administered his Rhopressa Ophthalmic Solution and Simbrinza Suspension (for open angle glaucoma), Tamsulosin HCl (for Genitourinary), and Mylanta Suspension (for gastroesophageal reflux disease).</li> </ol> <p>This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications or could result in worsening or exacerbation of chronic medical conditions.</p> <p>Findings included:</p> <p>Review of Resident #45's face sheet dated 08/27/24 reflected, Resident #45 was admitted to the facility on [DATE]. He was a [AGE] year-old male diagnosed with type 2 diabetes, hypertension, acquired absence of right and left leg above knee, and heart failure.</p> <p>Record review of Resident #45's initial MDS dated [DATE], reflected his BIMS score was 09, which indicated his cognition was moderately impaired.</p> <p>Record review of Resident #45's care plan dated 08/16/24 revealed he had thewas potential for complications related to atrial fib (Abnormal heartbeat), and hypertension, and the relevant interventions were administering medications as ordered, observing for effectiveness &amp;/or side effects, checking pulse daily &amp; prn and notify the physician of an irregular pulse rate &amp;/or as needed.</p> <p>Review of Resident #45's medication order reflected:</p> <p>Diltiazem HCl ER Capsule Extended Release 24 Hour 180 MG:</p> <p>Give 180mg by mouth one time a day for high blood pressure. Hold if systolic .</p> <p>&lt;100, HR &lt; 50. Start Date- 07/22/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Gabapentin Oral Capsule 300 MG (Gabapentin): Give 3 capsule by mouth three times a day for neuropathy pain. Start Date- 08/09/2024.</p> <p>Amiodarone HCl Oral Tablet 200 MG (Amiodarone HCl): Give 1 tablet by mouth three times a day for Antiarrhythmic (against abnormal heart rhythms) for 30 Days Hold if HR &lt; 50. Notify Dr. Start Date- 07/22/2024.</p> <p>Review of Resident #45's MAR of August 24 reflected Diltiazem HCL scheduled at 12:00PM on 08/01/24, 08/09/24, 08/15/24, 08/18/24, Gabapentin 300MG scheduled at 1:30PM on 08/15/24, 08/18/24, 08/22/24, and Amiodarone HCl 200 MG scheduled at 1:00PM on 08/15/24 and 08/18/24, were not administered. There was no reason marked for not administering the medications. Other medications scheduled on these days were administered indicating Resident #25 was present at the facility .</p> <p>Review of Resident #25's face sheet dated 08/29/24 reflected, Resident #25 was admitted to the facility on [DATE]. He was a [AGE] year-old male diagnosed with schizophrenia, abnormal weight loss, bipolar disorder, hypertension, heart failure and type 2 diabetes.</p> <p>Record review of Resident #25's quarterly MDS dated [DATE], reflected the attempt for assessment was conducted however the resident [NAME] rarely/never understood.</p> <p>Record review of Resident #25's care plan dated 07/12/24 revealed he was diagnosed with schizophrenia and, bipolar disorder. The relevant intervention was administering related medications and observe for side effect and adverse effects.</p> <p>Review of Resident #25's Medication order, reflected:</p> <p>Hydroxyzine Pamoate Capsule 50 MG: Give 1 capsule by mouth three times a day related to bipolar disorder, unspecified. Start Date-02/02/2023.</p> <p>Abilify Oral Tablet 5 MG (Aripiprazole) Give 1 tablet by mouth at bedtime, related to schizophrenia, unspecified. Start Date- 07/29/2024.</p> <p>Benzotropine Mesylate Tablet 1 MG Give 1 mg by mouth two times a day,  related to schizophrenia, unspecified. Start Date-12/10/2022.</p> <p>Divalproex Sodium ER Oral Tablet Extended Release: 24 Hour 250 MG (Divalproex Sodium) Give 1 tablet by mouth three times a day for agitation.  Start Date-05/24/2023.</p> <p>Gabapentin Capsule Give 300 mg by mouth two times a day related to bipolar .  disorder, unspecified. Start Date- 12/10/2022.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #45's MAR of August 24 reflected Hydroxyzine Pamoate 50 MG scheduled at 11:30AM on 08/02/24, 08/09/24, 08/11/24, 08/15/24, 08/16/24, 08/18/24, Abilify 5 MG scheduled at 8:00PM on 08/04/24, 08/09/24, 08/10/24, Benzotropine Mesylate 1MG scheduled at 8:00PM on 08/04/24, and 08/09/24, 08/10/24, Divalproex Sodium ER 250 MG scheduled on 08/02/24, 08/03/24, 08/09/24, 08/10/24, 08/11/24, 08/13/24, 08/15/24, 08/18/24, 08/19/24, 08/20/24, 08/22/24, and 08/24/24 and scheduled at 8:00PM on 08/04/24 and 08/09/24, and Gabapentin Capsule scheduled at 8:00PM on 08/04/24, 08/09/24, and 08/10/24, were not administered. There was no reason marked for not administering the medications. Other medications scheduled on these days were administered indicating Resident#25 was present at the facility .</p> <p>Review of Resident #10's face sheet dated 08/29/24 reflected, Resident #10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. He was a [AGE] year-old male diagnosed with hypertension, chronic obstructive pulmonary disease (breathing difficulty), gastroesophageal reflux disease (acid reflux), open angle glaucoma (a condition that causes gradual vision loss), dementia, psychotic disturbance, mood disturbance, and anxiety, and prostatic hyperplasia (prostate gland growth).</p> <p>Record review of Resident #10's quarterly MDS dated [DATE], reflected his BIMS assessment was not completed.</p> <p>Record review of Resident #10's care plan dated 07/05/24 revealed.</p> <p>Resident #10 has:</p> <ol style="list-style-type: none"> <li>1. Impaired vision related to disease process primary open-angle glaucoma, bilateral severe stage, retinal neovascularization, unspecified, right eye, and has gastroesophageal reflux disease.</li> <li>2. Incontinent of urine related to the disease process benign prostatic hyperplasia with lower urinary tract symptoms, and urinary frequency.</li> <li>3. Gastroesophageal reflux disease without esophagitis.</li> </ol> <p>The relevant interventions were, administering eyes drops and administering medications as ordered for gastroesophageal reflux disease and prostatic hyperplasia.</p> <p>Review of Resident # 10's medication order reflected:</p> <p>Rhopressa Ophthalmic Solution 0.02 % (Netarsudil Dimesylate): Instill 1 drop in both eyes two times a day related to primary open angle glaucoma, bilateral, severe stage. Start Date- 06/06/2024.</p> <p>Simbrinza Suspension 1-0.2 % (Brinzolamide- Brimonidine): Instill 1 drop in both eyes three times a day related to primary open angle glaucoma, bilateral, severe stage. Start Date- 05/06/2022.</p> <p>Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl): Give 1 capsule by mouth at bedtime for Genitourinary. -Start Date- 05/21/2023.</p> <p>Mylanta Suspension 200-200-20 MG/5ML (Alum &amp;Mag Hydroxide-Simeth): Give 30 cc by mouth before meals related to gastroesophageal reflux disease without esophagitis give 1 hour before meals. Start Date- 03/01/2016.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #45's MAR of August 24 reflected Rhopressa Ophthalmic Solution 0.02 % scheduled at 8:00PM on 08/02/24 and 08/10/24, Simbrinza Suspension 1-0.2 % at 1:00PM on 08/02/24, 08/09/24, 08/10/24, 08/10/24 , 08/11/24 , 08/13/24 , 08/15/24, 08/16/24 , 08/18/24, 08/19/24 , 08/20/24, 08/22/24, and 08/24/24, and Tamsulosin HCl Oral Capsule 0.4 MG scheduled at 208:00PM on 08/04/24 and 08/10/24, and Mylanta Suspension 200-200-20 MG/5ML scheduled at 11:00am on 08/09/24 , 08/10/24, 08/11/24, 08/15/24, and 08/16/24, were not administered. Other medications scheduled on these days were administered indicating Resident#25 was present at the facility.</p> <p>During a telephone interview on 08/29/24 at 3:30PM the MD stated that the nurses should follow the instruction in the medication order and administer the medications in a timely matter without any omissions. The MD said any significant adverse effect was unlikely with the omission of one or two doses of the medications that Resident #45, Resident #25, and Resident # 10 were taking. Adhering to the medication order regarding dose and frequency [NAME] very important as a persistent omission might affect the therapeutic level. The MD stated the issue of medication omissions whereas a relevant concern that would be included in the next QAPI meeting.</p> <p>During an interview on 08/30/24 at 3:00PM the DON stated the omission of medication administration by the MAs and nurses were not acceptable. She stated sheit was not sure if they were real omissions of medication administration or omission in documentation of the administration of medications. The DON said she did MAR auditing once in 15 days however she was unable to tell why these omissions were not captured in the audit. Also, the DON did not clarify when the previous MAR auditing was completed. She said in- services were conducted on a regular basis on medication administration . DON said omission of medication may affect the therapeutic effect of the medication and/ or delay the process of curing.</p> <p>Record review of the facility policy Administering medications revised in April 2019 reflected:</p> <p>Medications are administered in a safe and timely manner and as prescribed</p> <p>Medications are administered in accordance with prescriber orders, including any required time frame</p> <p>Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</b></p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 3 residents (Residents #45) reviewed for infection control., as indicated by:</p> <p>MA A did not clean and disinfect the wrist blood pressure monitor while using it on Resident #45.</p> <p>This failure could place the residents at risk of transmission of disease and infection.</p> <p>Findings included:</p> <p>Review of Resident #45's face sheet dated 08/27/24 reflected, Resident #45 was admitted to the facility on [DATE]. HShe was a [AGE] year-old male diagnosed with type 2 diabetes, hypertension, acquired absence of right and left leg above knee, and heart failure.</p> <p>Record review of Resident #45's initial MDS dated [DATE], reflected his BIMS score was 09, which indicateding his cognition was moderately impaired.</p> <p>Record review of Resident #45's care plan dated 08/16/24 revealed he had the potential for complications related atrial fib (Irregular Heart beat), the potential for complications related to hypertension, and the relevant interventions were administering related medications as ordered, observing for effectiveness &amp;/or side effects, and checking pulse daily &amp; prn and notifying the physician of an irregular pulse rate &amp;/or as needed.</p> <p>Review of Resident #45's the MAR for August 2024, reflected:</p> <p>Diltiazem HCl ER Capsule Extended Release 24 Hour 180 MG: Give 180 mg by mouth one time a day for high blood pressure, hold if systolic &lt;100, HR &lt; 50.</p> <p>An observation on 08/27/24 at 11:10 a.m., revealed MA A failed to sanitize the wrist blood pressure monitor before using it on Resident #45. MA A took the wrist blood pressure monitor from her scrub's pocket and without sanitizing it, applied it on Resident #45's wrist for taking his blood pressure.</p> <p>During an interview on 08/27/24 at 11:20 a.m., MA A stated she was working at the facility for about 3 years. MA A said she was concentrating on administering medications for the residents and forgot to sanitize the blood pressure cuff after she took it out from her pocket. She stated the monitor could get contaminated from the pocket and for that reason it was important to follow infection control protocol and sanitize the blood pressure cuffs before using it on the resident. She added, this was essential to minimize the risk of spreading contagious diseases. MA A stated she was aware of the importance of sanitizing medical equipment and received training however did not know the exactly when it was.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/29/24 at 1:30 p.m., the DON stated the facility policy provided very clear guidelines about the importance of sanitizing medical equipment. She stated the expectation was, the nursing staff was to follow the facility policy/procedure for handwashing and sanitization of medical equipment that included sanitizing the blood pressure monitor and make sure it was sanitized before applying it on a resident . She added, this was essential to stop spreading transmittable diseases.</p> <p>Review of the in-service records from 04/01/24 to 07/16/24 revealed there were no in- services conducted on disinfection of medical equipment.</p> <p>Review of facility's policy titled Cleaning and disinfection of Resident care Items revised in June 2011 reflected:</p> <p>The purpose of this procedure is to provide guidelines for disinfection of non-critical resident care items</p> <p>. 1. The following categories are used to distinguish the levels of sterilization/ disinfection necessary for items used in resident care . d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment)</p>		