

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER Woodland Springs Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Dallas St Waco, TX 76704	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety in the facility's only kitchen, reviewed for food safety. The facility failed to correctly label and date items in the dry storage and refrigerated areas. The facility failed to correctly label and date three containers of dry beans. There was one date on the container. No indication of what the items were and when they were placed in the container and when they should be used by. The pantry had several packages of dry cereal and pasta with only a date on the packages. There was no indication of when these items were opened and when the items should be discarded. In the walk-in refrigerator had an expired prepared item stored with a use by 11/15/2025 date stored inside. There were other undated items stored in the walk-in refrigerator as well. These failures could place residents at risk for food-borne illness and cross contamination. Observation of the kitchen on 12/02/2025 at 8:45 a.m., revealed in the dry storage area, three bins of dry beans with only one date on a label. These bins had a label with only one date marked on it. There was no indication when the items were placed in the container and when they could no longer be used. There were several bags of cereal that were opened and resealed that did not have dates indicating when they were opened and when they could no longer be used. There were two to three bags of pasta noodles that were not labeled and dated properly. Observation of the reach-in refrigerator on 12/02/2025 at 9:10 am., revealed a container with Zuc/Ham marked on the label with a use by date of 11/15/2025 on it stored in the walk-in refrigerator. There was a package of celery, a package of carrots, and beans with no date on the package stored in the refrigerator. In an interview with the Dietary Manager on 12/02/2025 at 9:25 a.m., stated that he recently started the position in the past few months and he did not receive any information from the previous manager. He stated he was trying to get things in order but has not gotten everything in place as he would like to. He hopes to have everything in order by the end of the year. He stated that he planned to use the USDA policies as the foundation to his new policies. He stated he understands the need to know when food comes in and when it should be discarded. He stated he does not want anyone to get sick from his kitchen. Interview with [NAME] A , on 12/03/2025 at 11:50 a.m., stated they all helped with putting up the food when the truck comes. She stated she marked her date on the package when she took it out of the box. Interview with [NAME] B 12/04/2025 at 1:25 p.m. revealed that everyone helped put the food on the shelf and they dated the box when they got it. Interview with the Administrator on 12/04/2025 at 2:15 p.m. revealed that the food manager is new and is doing a good job so far. He was unaware of the packaging not meeting the labeling requirement. Record review of the Facility Policy Food Receiving and Storage, Revised November 2022. Dry Food Storage 4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date) Such foods are rotated using a first in-first out system. Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date frozen or discarded.		

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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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for three (halls 100,200 and 300) of three halls reviewed for the pest control program.The facility had live gnats in a resident's room and numerous dead insects found in the catchment trays below the hand sanitizer disbursement units.This failure could place residents at risk for the spread of infection, cross-contamination and decreased quality of life.Findings included:In an observation on 12/02/2025 at 1:24 p.m., the wall mounted, Hand Sanitizer Automatic Disbursement Unit across from room [ROOM NUMBER]A the catchment tray below hand the sanitizer unit had four dead insects in the liquid collected in tray.In an observation on 12/02/2025 at 1:26 p.m., the wall mounted, Hand Sanitizer Automatic Disbursement Unit next to room [ROOM NUMBER] had a dead fly and two other dead insects in the catchment tray below the hand sanitizer unit.In an observation on 12/02/2025 at 1:27 p.m., the wall mounted, Hand Sanitizer Automatic Disbursement Unit next to room [ROOM NUMBER] had two dead insects in the catchment tray below the hand sanitizer unit.In an observation on 12/02/2025 at 1:28 p.m., the wall mounted, Hand Sanitizer Automatic Disbursement Unit next to 200-hall shower room (across) from room [ROOM NUMBER] was found to have one dead insect in the catchment tray below the hand sanitizer unit.In an observation on 12/02/2025 at 1:31 p.m., the wall mounted Hand Sanitizer Automatic Disbursement Unit on the 300-hall in front of shower room had one dead insect found in the catchment tray below the hand sanitizer unit.In an observation on 12/02/2025 at 1:32 p.m., the wall mounted Hand Sanitizer Automatic Disbursement Unit on the 300-hall next to room [ROOM NUMBER] had 30 plus dead insects observed in the catchment tray below the hand sanitizer unit.In an observation on 12/02/2025 at 1:33 p.m., the wall mounted Hand Sanitizer Automatic Disbursement Unit next to room [ROOM NUMBER] was found to have nine dead insects in the catchment tray below the hand sanitizer unit.In an observation on 12/02/2025 at 1:35 p.m., the wall mounted Hand Sanitizer Automatic Disbursement Unit next to room [ROOM NUMBER] was found to have six dead insects in the catchment tray below the hand sanitizer unit.In an observation and interview on 12/03/2025 at 9:54 a.m., CNA C was observed changing sheets in room # 326. Two live gnats were noted to have been flying around in the room. She stated she also had seen the gnats. She stated she had seen gnats in resident rooms around the facility. She stated that she would report insect problems in the pest sighting log or the maintenance log. Both Residents #1 and #3 were in the room but were unable to respond to questions due to severe cognitive impairment.In an interview on 12/02/2025 at 2:02 p.m., the Housekeeping Supervisor stated that her team was responsible for keeping resident rooms, hallways, bathrooms and common areas clean in the facility. She stated she was not aware of dead insects in the catchment trays below the hand sanitizers in the hallways. She stated she had seen a few gnats in resident rooms around the facility and that she and her staff were to write down sightings in the pest control logbook. She stated that the logbooks were behind the nursing station desks.In an interview on 12/03/2025 at 10:30 a.m., the Maintenance Supervisor stated that he and his assistant refilled the wall mounted hand sanitizer units. He stated he noticed the dead insects in the catchment trays below the units and that he would be sure to tell the Housekeeping Supervisor to have the units cleaned. He stated that staff could either tell him about insects in the facility or they could write it down in the pest sighting logbook found behind the nursing station. He stated that pest control visited the facility monthly and if needed could be called in more often.In an interview on 12/04/2025 at 10:19 a.m., the ADON stated that she was unaware of any insects in the catchment trays below the hand sanitizers. She stated she and the nursing staff used the wall mounted hand sanitizers every day, but she never noticed the dead insects until now and the nursing staff had not reported it to her. She stated having dead insects in plain view could affect residents' quality of life because it made the facility look dirty and that live insects could spread disease or cause cross-contamination.In an (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview on 12/04/2025 at 11:06 a.m., the ADM stated the Maintenance staff refilled and serviced the automatic hand sanitizers, but housekeeping was responsible for cleaning them. He stated having live insects in resident rooms or around the facility could cause cross contamination and that having dead insects visible in the hallways could affect resident's quality of life as the facility could be viewed as not clean. Record review of the Pest Sighting logbook from 06/01/2025 to 12/03/2025 found no entries from any staff. Review of the maintenance logbook from 06/01/2025 to 12/03/25 found one entry, dated 07/12/2025 referencing flies and gnats at the end of the 300-Hall. Record review of the Pest Control contract and visit receipt/descriptions of service found the contract was active. Pest Control visited the facility on a monthly basis with the last visit being 12/03/2025. No extra visits were found for the last 3 months. Record review of the grievance log from May 01, 2025 to present found no relevant complaints about insects from residents. Record review of the facility's policy revised July 2013 and titled Pest Control reflected Our facility shall maintain an effective pest control program . 1. This facility maintains an on-going pest control program for insects and rodents		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accident for four (Residents #12, #41 #90, and #91) of 6 residents reviewed for essential equipment. The facility failed to properly maintain wheelchairs for Residents #41, #90, #12, and #91. These failures could place residents at risk for equipment in unsafe operating condition, that could cause injury. Findings included: Record review of Resident #41's annual MDS assessment, dated 09/18/2025, reflected he was a [AGE] year-old male admitted [DATE] with diagnoses including dementia (confusion), hypertension (high blood pressure), and limited range of motion lower extremities (limited movement with legs). Further review of the MDS reflected the resident was severely cognitively impaired and unable to make decisions for themselves. Record review of Resident #41's plan of care, dated 09/18/2025 with updates, reflected goals and approaches included wheelchair mobility for locomotion. Observation and interview on 12/02/2025 at 8:30 a.m., revealed Resident #41 was sitting in his wheelchair, in the main dining room and had no skin problems. The wheelchair's right and left armrest were cracked with foam exposed. Resident #41 stated the wheelchair arms were rough and he did not like how it felt on his arms. Resident #41 stated he did not know who to tell about his wheelchair. Record review of Resident #90's quarterly MDS assessment, dated 10/06/2025, reflected he was an [AGE] year-old male admitted [DATE] with diagnoses including mood disorder (mental illness), hypertension (high blood pressure), and limited range of motion lower extremities (limited movement with legs). Further review of the MDS reflected the resident was moderately cognitively impaired and unable to make decisions for themselves. Record review of Resident #90's plan of care, dated 10/06/2025 with updates, reflected goals and approaches included wheelchair mobility for locomotion. Observation and interview on 12/02/2025 at 12:41 p.m., revealed Resident #90 was sitting in his wheelchair, in the main dining room and had no skin problems. The wheelchair's left armrest was cracked with foam exposed. Resident #90 stated that he was happy with his wheelchair, and he did not know who to tell about the armrest, but now that he thought about it could be fixed , so the wheelchair looked better. Record review of Resident #91's quarterly MDS assessment, dated 09/01/2025, reflected she was a [AGE] year-old female admitted on [DATE], with diagnoses including cerebral palsy (brain muscular disease), and anxiety (nervous disorder). Further review of the MDS reflected the resident was cognitively alert and able to make decisions for herself. Record review of Resident #91's care plan, dated 12/07/2025 with updates, reflected goals and approaches included wheelchair mobility. Observation and interview on 12/02/2025 at 12:00 p.m., revealed Resident #91 was sitting in her wheelchair in the main dining room and the wheelchair's left armrest was missing and right armrests were cracked with exposed foam. There were no skin tears on her arms. Resident #91 stated the armrest that was missing was cold. Resident #91 stated she had not told anyone about the armrest, she was just grateful to have a wheelchair. Review of Resident #12's quarterly MDS assessment, dated 11/12/2025, reflected she was a [AGE] year-old female admitted [DATE], with diagnoses including muscle weakness (generalized muscle weakness), and depression (sadness). Further review of the MDS reflected the resident was severely cognitively impaired and unable to make decisions for herself. Review of Resident 12's updated plan of care, dated 11/13/2025 with updates, reflected goals and approaches included wheelchair mobility. Observation and interview on 12/02/2025 at 12:12 p.m., revealed Resident #12, as in her wheelchair in the main dining room, and the wheelchair's right armrest was missing. The back of the wheelchair had a dried white substance on the entire back of the wheelchair. There were no skin tears on the arms. Resident #12 stated to leave her alone, she did not want to be spoken to. In an interview on 12/02/2025 at 12:15 p.m., CNA B stated when a resident's wheelchair needed repair the staff were to report it to the Director of (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Rehabilitation. CNA B was unaware of any log or system to be used to report broken equipment. CNA B stated she had not reported anything recently and was unaware of any equipment (wheelchairs) needing repair. In an interview on 12/03/2025 at 2:25 p.m., the Director of Rehabilitation revealed the staff reported to the rehab team if equipment needed repair. The Rehabilitation team will repair the wheelchairs. The supplies that are ordered for repair of the wheelchairs are ordered by the Director of Rehabilitation through the Administrator. The Director of Rehabilitation stated maintenance had nothing to do with the repair of the wheelchairs. If the facility needs new wheelchairs for the residents, the Rehabilitation team orders them. The Director of Rehabilitation stated if the wheelchair was a specialty chair, the team must contact the company that made the wheelchair. The Director of Rehabilitation stated there was no log for the staff to write in, the rehab department either saw the wheelchair or the staff told them directly if the wheelchair needed repair. The Rehabilitation Team did not make special rounds to search for wheelchairs that required repairs. In an interview on 12/04/2025 at 11:00 a.m., the Administrator revealed he did not have anything to do with the repair of wheelchairs. The Administrator stated if he saw worn wheelchairs, he informed the therapy department to order new ones. The Administrator stated he ordered new wheelchairs not too long ago, and there should be no wheelchairs that required repairs at the facility. The Administrator stated there was no system for communication concerning repair of wheelchairs. Review of the Facility's Policy titled Assistive Devices and Equipment dated revised July 2017 reflected, Our facility provides, maintains, trains and supervise the use of assistive devices and equipment for residents. 1. Devices and equipment that assist with resident mobility, safety, and independence and provided for residents. These include but are not limited to: a. Wheelchairs (manual and powered); . c. Device condition- devices and equipment will be maintained on schedule and . Defective or worn devices will be discarded or repaired.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe, functional, sanitary and comfortable environment for one (Hall 300) of three halls reviewed for environment. The facility failed to ensure bathroom floors and fixtures were in good repair for room numbers 350, 352, 354, and 355. This failure could place residents at risk for diminished quality of life due to the lack of a well-kempt environment. Findings included: An observation on 12/03/2025 at 9:54 a.m., of the bathroom for Room # 350 revealed the center drain in the middle of the bathroom floor had pushed through the tile approximately 1 inch, around a 7 inch crescent around the drain appeared to have missing tiles with some remaining tiles still connected to the central drain pipe presenting sharp tile edges and presenting a 3/4 inch raised possible trip hazard. An observation on 12/03/2025 at 9:56 a.m., of the bathroom in room [ROOM NUMBER] a patch of 2/2 inch tiles were missing from the floor exposing bare concrete in a patch of 6/4 inches, additionally the tiles behind the toilet had separated from the wall leaving a 1/2 gap between the floor and the wall and the tiles were discolored with a reddish stain that resembled rust. An observation on 12/03/2025 at 9:59 a.m., of the bathroom in room [ROOM NUMBER] revealed the bathroom was missing a bracket to hold toilet paper, approximately 3 feet along the edge of the floor and wall of the toilet appeared to be stained red resembling rust. An observation on 12/03/2025 at 10:02 a.m., of the bathroom in Room # 355 revealed the bathroom floor was missing a section of tiles approximately 8 inches by 6 inches exposing the bare concrete beneath and presenting a possible trip hazard. In an interview on 12/04/2025 at 10:30 a.m., the Maintenance Supervisor revealed he was aware of the issues with several bathrooms on the 300 Hall. He stated the building was settling and had broken some of the tiles and that some of the drainage pipes had raised up on one side of the hallway. He stated he was working on some bids to fix the bathrooms but would not be able to produce any proof of the bids or when the bathroom issues would be fixed. He stated the raised pipes and missing tiles could be a trip hazard. In an interview on 12/04/2025 at 11:06 a.m., the ADM revealed he had been aware of the bathroom floor/drainpipe issues on the 300 Hall, he stated the issues were being looked into but that he had no timeline for when the issues would be fixed. He stated that although there were residents living in those affected rooms/bathrooms, he had not received any complaints. He stated that having missing/discolored tiles and raised drainpipes in the resident bathrooms could present possible trip hazards and affect resident attitudes about the facility. He stated he would ask the Maintenance Supervisor to find some temporary fixes until the issues could be resolved. Review of the maintenance log from 06/01/2025 to 12/03/2025 found no entries for resident bathrooms. Review of a facility policy named Maintenance Service and dated December 2009 reflected that: Maintenance shall be provided to all areas of the building, grounds and equipment in a safe and operable manner at all times. a. Maintaining the building in compliance with current federal, state, and local laws, regulations and guidelines. b. maintaining the building in good repair and free from hazards		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat residents with respect and dignity for one (Resident #38) of eighteen residents reviewed for resident rights. The facility failed to ensure CNA A did not stand over Resident #38 while assisting the resident with his meal in the dining room on 12/02/2025. This failure could place residents at risk of feeling rushed to eat or not interested in eating, which could result in weight loss and decreased psycho-social well-being of anguish or frustration. Findings included: Record review of Resident #38's quarterly MDS Assessment, dated 10/01/2025, revealed a [AGE] year-old male who admitted [DATE] with a staff assessment BIMS score of 00 (Severely impaired). He required partial/moderate assist with eating and active diagnoses included Alzheimer's' disease (confusion and memory loss), dementia (confusion), anxiety disorder (nervous), and mood disorder (mental illness). He had a mechanically altered and therapeutic diet and issues with swallowing food and drinks. Record review of Resident #38's Care Plan, dated 01/31/2025, revealed, The resident has history of difficulty swallowing related to, dementia (confusion) and Alzheimer's disease (forgetfulness and confusion): Goals - The resident will not having choking episode through the next review period: 01/08/2025 and intervention: Eating - The resident requires set up assist of (1) staff for eating, and to monitor for changes in conditions with nutritional intake. Observation and interview attempt with Resident #38 on 12/02/2025 at 8:15 a.m. in the dining room on the secured unit revealed CNA A was standing next to Resident #38 who was sitting in his chair, the resident did not respond to any questions and just looked at staff. There was 90% of Resident #38's breakfast on her plate and CNA A had a spoon in her hand with food on it. CNA A lifted up the food and was telling Resident #38 he needed to eat his food and to try and take just a few more bites. Resident #38 opened his mouth and took the bite of food. He did not respond verbally to CNA A. Observation on 12/02/2025 at 12:15 p.m. in the dining room on the secured unit, CNA A was standing next to Resident #38 who was sitting in his chair. There was 45% of Resident #38's lunch on his plate and CNA A stated to the surveyor she was going to try and get him to take a couple of more bites of his lunch. The CNA A stated Resident #38 had a very good appetite. Resident #38 continued to eat until he completed his lunch meal. Interview on 12/02/2025 at 12:45 p.m., CNA A stated they were supposed to sit down to feed the residents. CNA A stated she knew she was supposed to have gotten a chair and she had just forgotten. CNA A said she was trained and it was against the residents' rights to stand over him while assisting him to eat. CNA A stated she was sorry, but the resident did not seem to notice she was standing because he still ate well. CNA A stated she was in-serviced on Resident Rights and knew this was part of not dignifying their rights. Interview on 12/02/2025 at 10:45 a.m., the DON stated the staff should be seated at eye level when assisting the residents to eat. She stated sitting down while assisting the residents to eat was good for the staff to see how the residents swallowed. She stated feeding the residents standing up was a dignity issue. Record Review of the in-service, dated 09/2025, reflected Resident Rights . To include how to assist a resident to eat with dignity. CNA A had signed the in-service to have attended. Record Review of the facility policy and procedure titled Assistance with meals, dated July 2017, reflected Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. Not standing over residents while assisting them with meals; .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 (CNA B) staff members and 1 of 2 residents (Resident #19) reviewed for infection control procedures. CNA B failed to change their soiled gloves and perform hand hygiene during incontinent care for Resident #19. These failures could place residents at risk for cross contamination and infections. Findings included:Record review of Resident #19's quarterly MDS Assessment, dated 09/01/2025, revealed an [AGE] year-old male admitted on [DATE]. Resident #19 had diagnoses which included Alzheimer's disease (forgetfulness and confusion), anorexia, (does not want to eat), and dementia (confusion). Resident #19 was severely cognitively impaired and unable to make decisions for himself and required one staff member for assistance with activities of daily living. Observation on 12/04/2025 at 1:30 p.m., CNA B entered the room to perform incontinent care and activities of daily living with Resident #19. During this time an attempt was made to interview Resident #19 , he did not respond to questions and did not communicate during the observation. CNA B used hand gel in the hallway and placed gloves on. CNA B picked up her incontinent wipes and entered the room. Resident #19 was lying on his left side in the bed. CNA B explained to the resident what she was going to do, and the resident agreed. CNA B pulled the pants of Resident #19 down; he had taken off his brief, had smeared bowel movement on his pants and had placed his brief in the trashcan. CNA B wiped the penal shaft area with a disposable wipe, discarded the wipe. CNA B used another wipe on the groin area and discarded it. CNA B assisted with repositioning Resident #19 to his right side. CNA B then used another wipe on the left buttocks and then used another wipe on the right buttocks. CNA B used another wipe on the rectum, after placing a clean brief under Resident #19, discarding dirty wipes. CNA B assisted with repositioning Resident #19 to his left side while pulling the clean brief under the resident. CNA B, without changing her soiled gloves or washing her hands, fastened the tabs of the clean brief. CNA B then with her soiled gloves opened the drawers, looked for clean pants, while touching all the clothing in the drawer. CNA B located a pair of clean pants, placed on the resident's pants, assisted with repositioning him on his back and covering him with a sheet and a blanket. CNA B placed her gloves in the trashcan, gathered the trash bag, placed the incontinent wipes back on top of the dresser, and left the room, without washing her hands or using hand sanitizer. An interview on 12/02/2025 at 2:00 p.m., CNA B stated she got nervous when the surveyor entered the room with her and forgot what to do. CNA B stated she knew she did not change her gloves or wash her hands. CNA B stated she was trained in infection control, changing gloves and handwashing. The CNA stated that if she did not change her gloves and wash her hands or use sanitizer, she could spread germs to herself and other residents.An interview with the DON, who was the infection control preventionist on 12/04/2025 at 10:45 a.m., the DON stated the staff when performing incontinent care should be changing gloves from dirty to clean and washing their hands or using the available hand sanitizer. The DON stated she just had an in-service in the past 3 months presenting the importance of changing gloves and washing hands during care and incontinent care and CNA B was in attendance. The DON stated during the in-service the staff did not ask any questions and appeared to understand and indicated they knew everything. The DON stated if the CNA appeared nervous then the staff would do what they would usually. The DON stated if the staff did not change gloves and clean their hands when they should, they could spread germs to themselves and the residents.Record review of the in-service dated 10/19/2025 reflected infection control/hand hygiene. The in-service included proper procedure as to when to wash hands, wear gloves, and what to do while performing incontinent care. CNA B had signed the attendee record for the training. Record review of the Facility's Policy titled Handwashing/Hand Hygiene, dated October 2023, reflected: Policy statement: This facility considers (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER Woodland Springs Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Dallas St Waco, TX 76704	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand hygiene the primary means to prevent the spread of healthcare-associated infections. Indications for hand hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident; . c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. 5. The use of gloves does not replace handwashing/hand hygiene Record review of the Facility's Policy titled Perineal Care, dated February 2018 reflected: Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritations, and to observe the resident's skin condition . Steps to procedure 1. Place equipment on bedside . 2. Wash and dry your hands thoroughly . 7. Put on gloves . [steps to perform incontinent care for male/female] . 10. Remove gloves and discard into designated container. 11. Wash and dry hands thoroughly. 12. Reposition the bed covers. Make the resident comfortable . 16. Wash and dry hands thoroughly		