STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675637	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wooldridge Place Nursing Center	7352 Wooldridge Rd Corpus Christi, TX 78414

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to report an alleged violation of abuse for (1 of 4 residents) in a timely manner.The facility failed to report to the state of Texas within 24 hours indicating Resident #1 hit her head, in a timely manner. R#1 hit her head during transport on March 7, 2005, the facility reported the incident 3 months later.This failure could place residents at risk for abuse and neglect. Findings included:Record review of Resident #1's face sheet dated June 30, 2025, revealed she was an [AGE] year-old female, admitted on [DATE], Resident #1 had a medical dx of Dementia (a group of thinking and social symptoms that interferes with daily function), Alzheimer's (a progressive disease that destroys memory and other important functions), Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone), Muscle Weakness, Abnormal Gait (abnormal way of walking), and Lack of Coordination. An MDS assessment dated [DATE], revealed Resident #1 had a BIMS (brief interview of mental status) score of 15 (indicating resident is cognitively intact) and needed help with transferring and toileting. The MDS also indicated Resident #1 used a walker to assist with ambulation. Resident #1 was mostly independent in activities of daily living other than shower and toileting with minimal assistance. Record review of Resident #1's care plan, undated, revealed The resident has impaired cognitive ability /impaired thought processes related to Dementia. Interventions included: Allowing extra time for resident to respond to questions and instructions and to speak clearly when talking with the resident. During an interview on June 30, 2025, at 3:30 p.m., Resident #1 stated she was with one of the CNAs and the van driver going to an eye appointment, or coming back, and when she was walking into the van, she hit her head on the ceiling of the van. Resident #1 stated she could not remember the date it happened. Resident #1 stated it didn't hurt and she was okay. Resident #1 stated hitting her head surprised her. Resident #1 stated the van driver looked at her head, but it was fine. Resident #1 stated that is all she can recall from hitting her head; everything else went okay. During an interview on June 30, 2025, at 11:15 a.m., the facility Van Driver stated Resident #1 informed him she hit her head on the van ceiling when getting into the van. The Van Driver stated, CNA A and myself were telling her to duck down when walking into the van, but he did not see her hit her head. The Van Driver stated it happened just as hewas walking around the van. The van driver stated when she told me, he looked at her head and he didn't see any redness, bruising, or bump, and the resident said she was okay. The Van Driver stated he did not report the incident because the resident said she was okay. The Van Driver stated he was trained on abuse, neglect and exploitation and should have reported it to the nursing staff and to the Administrator. During an interview on June 30, 2025, at 11:45 a.m., CNA A stated while escorting Resident #1 to an eye appointment on March 7th, 2025, the resident claimed she hit her head on the ceiling of the van when walking with a walker to get into the van. CNA A stated she did not see it happen, but the resident said she was okay and there was no bump, bruise or abrasion on the resident's head and there were not any issues later. CNA A stated we told Resident #1 to duck down and to watch out for the low part of the ceiling. CNA A stated she did not report it to my manager or the Administrator because she just didn't. CNA A stated she should have reported it and she knew she should have but she didn't report it. CNA A stated she was trained on abuse, neglect, and exploitation. During an interview on 7/11/25 at 1:35 p.m., with the Administrator, he stated he found out Resident #1 hit her head while being transported to her eye doctor 3 months after the incident happened. The Administrator stated his expectations were to be to be informed of any resident hitting their head, or any occurrence immediately. The Administrator also stated staff did not connect that even though they didn't see anything (redness, abrasion and /or bruising) they did need to report this incident occurred. The Administrator stated the staff (Van driver and CNA A) rationalized that because they did not see any injury and the resident stated she was fine, they did not need to report it. They should have reported it because there was still a possibility that she was injured. The Administrator stated Resident #1 was assessed and no head injuries noted. The Administrator stated it was and is my responsibility to complete the investigation of abuse or neglect and our findings were unfounded for the allegation of neglect or abuse, however we still did a thorough investigation including reviewing the resident's full chart. We (myself and the DON) interviewed all residents that traveled with both staff members during the time this occurred in March up until then. There were 7 residents, and all residents reported feeling safe around the staff, and no one has hit their head on the ceiling of the van. The Administrator also stated both staff members were suspended during this investigation and both staff members received corrective action