| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675668 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wood Memorial Nursing and Rehabilitation | 320 Greenville Highway<br>Mineola, TX 75773 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical and mental status that was, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) 1 of 13 (Resident #2) residents reviewed for notification of change. The facility did not notify the physician of Resident #2's weeping edema (a condition where fluid leaks from the skin), redness, and blister to her right leg. LVN B or D had not notified the physician or NP to obtain an order for an ace wrap or notify them of the swelling and weeping to Resident #2's right leg on 08/29/2025. The facility did not ensure physician orders were obtained for treatment of Resident #'2's swollen and weeping leg or application of dressings prior to applying dressings to Resident #2's leg. This failure could place residents at risk for not receiving care and services to meet resident needs.Findings included: Record review of the face sheet dated 8/29/25 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including edema (swelling that occurs when fluid builds up on the body's tissues), hypertension (elevated blood pressure), and congestive heart failure (a chronic condition in which the heart does not pump blood as good as it should with symptoms including swollen legs). Record review of the MDS dated [DATE] indicated Resident #2 was admitted to the facility on [DATE]. Record review of the base line care plan dated 8/20/25 indicated Resident #2's needs, risks, strengths, and goals would be identified for the first 48 hours. Record review of Resident #2's orders dated 7/29/25 through 8/29/25 indicated she did not have an order for wound care or a dressing to be applied to her right leg. During an observation and interview on 8/29/25 at 10:12 a.m. Resident #2 was observed with a nonstick dressing to her right shin and wrap gauze down around her ankle. Resident #2's right leg was observed to be swollen with redness from approximately mid shin to her ankle. Resident #2 said a nurse (name unknown) had put the dressing and gauze on her leg due to a weeping blister on her shin. Resident #2 said another nurse (name unknown) after she first admitted to the facility (date unknown) had wrapped her leg with an ace bandage to catch the weeping due to her leg weeping and getting her sheets wet. During an interview on 8/29/25 at 10:36 a.m. the Physician said he was unsure whether he had been contacted regarding Resident #2's leg weeping or need for a dressing. The Physician said his NP usually takes daily calls from nursing facilities. The Physician said he was taking the calls at this time due to his NP being out of the country. The Physician said if he had been contacted regarding swelling to a resident's leg, he probably would have added a diuretic medication (a medication that increases urine production and sodium excretion to treat fluid buildup). The Physician asked the surveyor to have the DON look at Resident #2's leg and call him. During an observation and interview on 8/29/25 on 10:45 a.m. the surveyor observed Resident #2's right leg with the DON. The DON said she was not aware a dressing had been put on Resident #2's right leg. The DON removed the dressing and assessed Resident #2's right leg. The DON said Resident #2's right leg was red and swollen. The DON said she was aware that LVN B had previously wrapped Resident #2's right leg with an ace wrap due to swelling and weeping. The DON said LVN B had not notified the physician or NP to obtain an order for the ace wrap or to notify them of the swelling and weeping to Resident #2's right leg. The DON said the LVN C, had been the nurse who had discovered and reported to the ADON that Resident #2's right leg was wrapped with an ace wrap. During an interview on 8/29/25 at 10:50 a.m. LVN D said she was working on 8/28/25 and Resident #2 came to her after dinner and showed her what appeared to be a burst blister with drainage to her right leg. LVN D said she applied a non-stick dressing to the area and wrapped it with wrap gauze. LVN D said she had intentions to but never notified the physician or obtained an order for the dressing. During an interview on 8/29/25 at 10:55 a.m. the DON said she expected staff to notify the physician of changes in condition including skin conditions, swelling, or weeping. During an interview attempt on 8/29/25 at 12:16 p.m. LVN B did not answer the phone and her voicemail was full. During an interview on 8/29/25 at 2:06 p.m. the DON the importance of notifying the physician of a change in condition was to get the appropriate diagnosis and treatment for a resident. Record review of the facility's Change in a Resident's Condition or Status policy last revised 6/2025 indicated, Our facility promptly notifies the resident, his or her attending physician, healthcare provider, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician, healthcare provider, or physician on call when there had been a(an): b. discovery of injuries of unknown origin d. significant change in the resident's |

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| Wood Memorial Nursing and Rehabilitation | 320 Greenville Highway<br>Mineola, TX 75773 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms 1 of 13 (Resident #1) residents reviewed for restraints. The facility failed to ensure Resident #1 was administered her Xanax (medication used to treat anxiety) every 8 hours as needed per the physician's orders instead of Resident #1 having it administered in less than 8 hours on several dates in July 2025 by LVN A and LVN B to keep Resident #1 quiet. This failure could place residents who receive psychotropic medications at risk of not receiving the intended therapeutic benefit of the medications.Findings included: Record review of the face sheet dated 8/29/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including anxiety, dementia, muscle weakness, lack of coordination, and restlessness and agitation. Record review of the entry MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 09 and was moderately cognitively impaired. Record review of the care plan revised on 8/14/25 indicated Resident #1 was at risk for variations in mood related to impaired cognition, major depressive disorder, anxiety, and schizoaffective disorder bipolar type (a mental health condition that combines symptoms of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and bipolar disorder (a disorder associated with episodes of mood swings). Record review of the order history dated 7/29/25 through 8/29/25 indicated Resident #1 had an order for a Xanax 1mg every 8 hours as needed starting 3/26/25. Record review of the narcotic count sheet for Resident #1's Xanax 1mg indicated Resident #1 was administered the Xanax in less than 8 hours on the following dates: 7/17/25 administered at 4:00 a.m. by an unknown nurse and again at 8:00 a.m. by LVN B. 7/21/25 administered at 9:30 a.m. by LVN B and again at 2:30 p.m. by LVN B. 7/22/25 administered at 8:45 a.m. by LVN B and again at 2:30 p.m. by LVN B. 7/27/25 administered at 10:15 a.m. by LVN B and again at 4:15 p.m. by LVN B. 7/28/25 administered at 4:00 a.m. by the AON and again at 10:15 a.m. by LVN B. 7/29/25 administered at 8:16 a.m. by LVN A and again at 3:00 p.m. by LVN A. 7/31/25 administered at 2:00 p.m.by LVN A and again at 6:00 p.m. by LVN A. Record review of the MAR indicated Resident #1's Xanax administration was not documented on 7/17/25, 7/21/25, 7/22/25, 7/27/25, or 7/31/25. The MAR indicated Resident #1's Xanax administration was only documented on 7/28/25 at 4:00 a.m. and 7/29/25 at 8:17 a.m. During an interview on 8/29/25 at 8:44 a.m. the ADON said LVN A was no longer employed at the facility. During an interview on 8/29/25 at 8:45 am LVN B said she had administered Resident #1's Xanax in less than the ordered 8 hours because giving Resident #1 her as needed Xanax was LVN B's answer to Resident #1's behaviors. LVN B said she felt like she needed to keep Resident #1 quiet when she was having behaviors of yelling out. LVN B said she has since learned there are other ways to handle resident behaviors. LVN B said she should have been documenting the as needed Xanax administration on the MAR. LVN B said she was getting better about documenting as needed medication administration on residents' MARs. During an interview on 8/29/25 at 2:06 pm the DON said she expected the nurses to assess and document assessment prior to administering as needed medication. The DON said she expected the nurses to administer as needed medication as ordered and in at least the minimum time frame ordered if needed. The DON said as needed medication do not fall in the hour before hour after parameters that scheduled medication can be given. The DON said as needed medication effectiveness should be documented and if a nurse determines the medication was not being effective within the time frames it is ordered, then she expected them (staff) to notify the physician, and not give the medication earlier than ordered. The DON said the importance of following the physician's orders and administering as needed medications as ordered was not to overmedicate the resident and be able to signify if a medication was effective within the parameters ordered. The DON said she expected all medications including as needed medications to be documented in the EMR. The DON said the importance of documenting in the EMR was that was the official documentation indicating a medication had been administered and it allowed other nurses to know when a resident least had a medication and the medications effectiveness. Record review of the facility's Medication Administration-General Guidelines policy dated 6/1/22 indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.A. Preparation.4. Five Rights- right resident, right drug, right dose, right route, and right time, are applied for each medication being administered |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 13 (Resident #2) residents reviewed for quality of care. The facility did not notify the physician of Resident #2's weeping edema (a condition where fluid leaks from the skin), redness, and blister to her right leg. The facility did not ensure physician orders were obtained for treatment of Resident #'2's swollen and weeping leg or application of dressings prior to applying dressings to Resident #2's leg. These failures could place residents at risk for not receiving care and services to meet resident needs and decreased quality of life. Findings included: Record review of the face sheet dated 8/29/25 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including edema (swelling that occurs when fluid builds up on the body's tissues), hypertension (elevated blood pressure), and congestive heart failure (a chronic condition in which the heart does not pump blood as good as it should with symptoms including swollen legs). Record review of the MDS dated [DATE] indicated Resident #2 was admitted to the facility on [DATE]. Record review of the base line care plan dated 8/20/25 indicated Resident #2's needs, risks, strengths, and goals would be identified for the first 48 hours. Record review of Resident #2's orders dated 7/29/25 through 8/29/25 indicated she did not have an order for wound care or a dressing to be applied to her right leg. During an observation and interview on 8/29/25 at 10:12 a.m. Resident #2 was observed with a nonstick dressing to her right shin and wrap gauze down around her ankle. Resident #2's right leg was observed to be swollen with redness from approximately mid shin to her ankle. Resident #2 said a nurse (name unknown) had put the dressing and gauze on her leg due to a weeping blister on her shin. Resident #2 said another nurse (name unknown) after she first admitted to the facility (date unknown) had wrapped her leg with an ace bandage to catch the weeping due to her leg weeping and getting her sheets wet. During an interview on 8/29/25 at 10:36 a.m. the Physician said he was unsure whether he had been contacted regarding Resident #2's leg weeping or need for a dressing. The Physician said his NP usually takes daily calls from nursing facilities. The Physician said he was taking the calls at this time due to his NP being out of the country. The Physician said if he had been contacted regarding swelling to a resident's leg, he probably would have added a diuretic medication (a medication that increases urine production and sodium excretion to treat fluid buildup). The Physician asked the surveyor to have the DON look at Resident #2's leg and call him. During an observation and interview on 8/29/25 on 10:45 a.m. the surveyor observed Resident #2's right leg with the DON. The DON said she was not aware a dressing had been put on Resident #2's right leg. The DON removed the dressing and assessed Resident #2's right leg. The DON said Resident #2's right leg was red and swollen. The DON said she was aware that LVN B had previously wrapped Resident #2's right leg with an ace wrap due to swelling and weeping. The DON said LVN B had not notified the physician or NP to obtain an order for the ace wrap or to notify them of the swelling and weeping to Resident #2's right leg. The DON said the LVN C, had been the nurse who had discovered and reported to the ADON that Resident #2's right leg was wrapped with an ace wrap. During an interview on 8/29/25 at 10:50 a.m. LVN D said she was working on 8/28/25 and Resident #2 came to her after dinner and showed her what appeared to be a burst blister with drainage to her right leg. LVN D said she applied a non-stick dressing to the area and wrapped it with wrap gauze. LVN D said she had intentions to but never notified the physician or obtained an order for the dressing. During an interview on 8/29/25 at 10:55 a.m. the DON said she expected staff to notify the physician of changes in condition including skin conditions, swelling, or weeping. During an interview attempt on 8/29/25 at 12:16 p.m. LVN B did not answer the phone and her voicemail was full. During an interview on 8/29/25 at 2:06 p.m. the DON the importance of notifying the physician of a change in condition was to get the appropriate diagnosis and treatment for a resident. Record review of the facility's Change in a Resident's Condition or Status policy last revised 6/2025 indicated, Our facility promptly notifies the resident, his or her attending physician, healthcare provider, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician, healthcare provider, or physician on call when there had been a(an):.b. discovery of injuries of unknown origin.d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly.Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status. |

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| F 0729<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure registry verification was received that the individual had met competency evaluation requirements before they were allowed to work as a nurse aide for 1 of 4 (CNA E) employees reviewed for registry verification. The facility failed to ensure CNA E had a current nurse aide certification while employed at the facility and actively providing care for residents from [DATE] through [DATE]. CNA E certificate expired on [DATE]. This failure placed residents at risk for decreased quality of care. Findings included:Record review of CNA E's employee file indicated her nurse aide certification was issued on [DATE] and would expire on [DATE]. The employee file indicated CNA E's initial nurse aide certification was issued on [DATE]. The employee file indicated she applied to the facility on [DATE] and was available for work on [DATE]. The employee application indicated her nurse aide certification would expire on [DATE]. Record review of CNA E's time sheets from [DATE] through [DATE] indicated other than 4 days of PTO, she had taken CNA E had worked her normal full-time shift at the facility. During an interview on [DATE] at 11:50 a.m. the BOM said CNA E's nurse aide certification expired on [DATE]. The BOM said when LVN C brought it to her attention that CNA E had an expired nurse aide certification she pulled the certification in TULIP and saw it had been renewed on [DATE]. The BOM said she did not know how many if any days CNA E had worked with an expired nurse aide certification or why CNA E did not renew her nurse aide certification by [DATE]. The BOM said she did not know how LVN C was aware of CNA E's expired nurse aide certification or what date she was notified on. During an interview on [DATE] at 12:35 p.m. the Administrator said he had not been aware CNA E had been working with an expired nurse aide certification until she told them. The Administrator said the facility and corporate do monitor for expired or expiring license and certifications, but CNA E had not showed up on any of their lists. The Administrator said CNA E told them she had not renewed her certification because she did not know how to work TULIP. During an interview on [DATE] at 12:41 p.m. CNA E said her nurse aide certification was expired for several months without her realizing it because she thought the facility would renew it for her like her previous facility did. CNA E said when she realized her nurse aide certification was expired due to her working nights, she had not gone up to the facility to have them assist her with the renewal paperwork. CNA E said there was really no excuse for her nurse aide certification being expired for so long. During an interview on [DATE] at 2:25 p. m. the Administrator said the facility did not have a policy regarding nurse aide certification renewal/expirations/registry. The Administrator said the facility did have an annual employee checklist that was supposed to be completed on all employees annually. |