STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675668	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation	320 Greenville Highway 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 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. Based on observation and interview the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 1 secured unit living rooms observed. The facility failed to ensure CNA D and LVN B did not have a blanket covering the overhead light in the secured unit living room on 9/18/25. This failure places residents at risk for a fire hazard and decreased quality of life.Findings Include:During an observation on 9/18/25 at 4:35 a.m. LVN B and CNA D were in the secured unit living room with a blanket covering the overhead light. LVN B was observed removing the blanket when the surveyor and a CNA walked into the secured unit living room. During an interview on 9/18/25 at 4:41 a.m. LVN B said covering the overhead light in the living room of the secured unit was not safe. LVN B said CNA D usually covered the overhead light in the secured unit dining room with a blanket. LVN B said a blanket covering a light could get too hot and catch fire. During an interview on 9/18/25 at 4:45 a.m. CNA D said she usually hung a blanket over the overhead light in the secured unit living room because the light could not be turned off and it shined directly into Resident #1's room. CNA D said the switch to the light in the secured unit living room did not work. CNA D said she kept Resident #1's door open so she could hear him because of his history of wandering. CNA D said she did not know if it was safe or not to cover the overhead light with a blanket. During an interview on 9/18/25 at 8:00 a.m. the Maintenance Director said the light switch in the living room of the secured unit was disconnected and not dysfunctional. The Maintenance Director said the light switch was disconnected before he had started at the facility, and it was disconnected to prevent staff from turning it off at night and sleeping while on the job. The Maintenance Director said staff should not be hanging a blanket over any light in the facility. The Maintenance Director said it was a fire hazard to hang a blanket or cloth over a light because light bulbs get hot and can catch the fabric on fire. During an interview on 9/18/25 at 8:22 a.m. the Administrator said he was not aware of the light switch in the living room of the secured unit being disconnected. The Administrator said staff should not cover lights with anything. The Administrator said covering lights with cloth was a fire hazard. During an interview on 9/18/25 at 9:29 a.m. the Administrator said the facility did not have a policy regarding covering lights with anything including cloth items.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675668	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675668	A. Building B. Wing	09/18/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, in accordance with State and Federal laws, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys on 3 of 7 (Medication Cart #1, Medication Cart #2, and Medication Cart #3) medication carts reviewed for labeling and storage of medication. The facility did not ensure the Medication Cart #1 (medication cart for the secured unit), Medication Cart #2 (nurse's medication cart for the west side of the building) and Medication Cart #3 ((nurse's medication cart for the east side of the building) were secured and unable to be accessed by unauthorized personnel on 9/18/25. This failure could place residents at risk for not receiving drugs and biologicals as needed or a drug diversion.Findings include: 1. During an observation on 9/18/25 at 4:30 a.m. Medication Cart #1 was in of the hallway unsupervised and unlocked. A CNA was walking by Medication cart #1 pushing a resident in their wheelchair down the hallway. 2. During an observation on 9/18/25 at 4:32 a.m. Medication Cart #2 was in of the hallway unsupervised and unlocked. A resident was wheeling themselves in their wheelchair down the hallway past Medication Cart #2. During an interview on 9/18/25 at 4:42 a.m. LVN B said Medication Cart #1 was the med cart for the secured unit and Medication Cart #2 was the nurse's med cart for the west side of the building. LVN B said both med carts had medication in them. LVN B said he did not usually keep the medication carts unlocked. LVN B said the medication cart was unlocked because he had recently used them. LVN B said the importance of keeping medication carts locked was to prevent the loss of medications and to keep residents from getting into them. 2. During an observation on 9/18/25 at 4:36 a.m. Medication Cart #3 was unlocked. LVN A was walking down the hall away from Medication Cart #3 with his back to the med cart. During an interview on 9/18/25 at 4:48 a.m. LVN A said Medication Cart #3 was the nurse's med cart for the east side of the building. LVN A said Med Cart #3 was unlocked because he had been working out of the nurse's med cart, the med aide med cart, and the treatment cart. LVN A said he would lock Medication Cart #3 if the surveyor wanted him to. LVN A said Medication Cart #3 was in his sight. LVN A said the importance of keeping the medication cart locked was so someone did not get into them and take medications. LVN A said Medication Cart #3 had PRN medication in it. 3. During an observation on 9/18/25 at 6:50 a.m. Medication Cart #1 was unlocked in hallway of secured unit with 2 residents sitting in wheelchairs on either side of the med cart. During an interview on 9/18/25 at 6:52 am LVN C said she had left Medication Cart #1 unlocked while trying to get residents' blood pressures so she could pass medication prior to breakfast. LVN C said sometimes she did leave her med cart unlocked. LVN C said the importance in ensuring medication cart were locked was to prevent residents from getting medication out of the medication cart and taking a medication, they were not prescribed. During an interview on 9/18/25 at 8:22 a.m. the Administrator said medication carts should be locked when staff are not getting something out of them. The Administrator said the importance of keeping medication carts locked was to prevent residents from getting in them and taking medication not prescribed to them and to prevent staff from being able to get in the carts and steal medications. During an interview on 9/18/25 at 8:52 a.m. the ADON said medication carts should not be unlocked unless the staff member assigned to that particular cart is actively getting medications out of it or standing directly in front of the medication cart. The ADON said the importance of ensuring medications cart were locked was to prevent anyone else accessing the medications, cream, insulins, etc. that are store on the cart. Record review of the facility's Medication Storage in the Facility policy dated 6/1/22 indicated, Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.