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	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation Center	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review the facility failed to ensure the residents or responsible party had the right to be informed of and participate in his or her treatment which included, the right to be informed in advance, by the physician or other practitioner or other professional, of the risks and benefits of proposed care, treatment, and treatment alternatives or treatment options to choose the alternative or option he or she preferred for 1 of 4 residents (Resident #74) reviewed for psychoactive medications. The facility failed to ensure LVN B obtained informed consent based on the information of the benefits and risks for Resident #74 before administering Klonopin (Clonazepam), a medication used to treat anxiety on 08/28/24. This failure could place residents at risk of receiving medications they had not consented to, experiencing potential adverse reactions, and a potential decline in physical and mental health status. Findings included: Record review of Resident #74's face sheet, dated 09/11/24 indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and depression (sadness). Record review of Resident #74's quarterly MDS assessment, dated 08/06/24 indicated Resident #74 was sometimes understood and was sometimes understood by others. Resident #74 had short and long-term memory loss which indicated she was cognitively impaired. The MDS indicated Resident #74 required total or extensive help with toileting bed mobility, dressing, transfers, personal hygiene, and supervision with eating. The MDS indicated she took antianxiety medication during the 7-day look-back period. Record review of Resident #74's physician order dated 08/24/24 reflected Klonopin (Clonazepam) 1MG, give 1 tablet by mouth 3 times a day for anxiety. Record review of Resident #74's medication administration record dated from 08/28/24 through 09/11/24 revealed Resident#74 received Klonopin (Clonazepam) 1MG, by mouth 3 times a day for anxiety. (continued on next page)

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
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #74's care plan dated 08/12/24 indicated she required antianxiety medication. The intervention of the care plan indicated staff would give medication as ordered. Staff would monitor for drug use effectiveness, adverse consequences, mood, and response to medication. Record review of Resident #74's consent for the use of psychotropic medication, Klonopin (Clonazepam) 1MG for anxiety was not documented in her chart from 08/28/24 through 09/11/24. During an interview on 09/11/24 at 2:07 p.m., LVN B said consent(s) were obtained to notify the resident or the responsible party of their orders and to verify it was okay to give. She said consent(s) should have been obtained for all psychotropic medication before being given. She said she was the nurse who took the order for Resident #74's increase in Klonopin. LVN B said she did not notify the family because the resident was already on this medication, and it was an increase. LVN B said she was not aware of how the previous consent was written. During attempted interviews on 09/11/24 at 2:20 p.m., Resident #74's RP did not answer the telephone. Resident #74 could not answer when asked about her medications. During an interview on 09/11/24 at 3:47 p.m., the ADON said the nurse who received the order was responsible for getting the consent. The ADON said the consent for psychotropic medications should have been completed before the resident received the medication. The ADON said she and the DON usually reviewed all new orders and consents as part of the morning meeting process for all psychotropic medication. The. The ADON said it was important to get consent because these types of medications could alter the mind and could cause other risks. During an interview on 09/11/24 at 4:11 p.m., the DON said when they receive an order for a psychoactive medication, they should inform the resident or RP. She said if the resident or RP refused the medication, they would notify the doctor. She said once the consent had been signed then they could give the medication. She said the signed consent should have been scanned into the resident's electronic medical records. The DON said she and the ADON oversaw this process. She said failure to get consent even if an increase in medication could cause family not to be aware of their loved ones' care. During an interview on 09/11/24 at 4:48 p.m., the Administrator said consent should be done to inform families or residents of the risks and/or benefits of a medication. The Administrator said the ADON, and the DON oversaw this process. Record review of the facility's policy titled, Psychoactive Medications, dated July 2024 reflected Policy: Residents are not given psychotropic medications unless the drug is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Definition: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guidelines: 1. The attending physician and/or psychiatric provider will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families or representatives, the interdisciplinary team, and other professionals.3. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46928 Based on observation, interviews and record review, the facility failed to ensure residents had the right to a clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safety, clean bed and bath linens for 1 of 1 facility reviewed for resident rights. The facility failed to ensure clean towels and wash rags were available for use on 09/11/24. This failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: During an observation on 09/11/24 at 10:42 AM revealed the clean linen closet on hall B had only gowns and pillowcases. There were no fitted sheets, flat sheets, towels or wash rags available for use. During an observation on 09/11/24 at 10:43 AM revealed the hall B clean linen cart only had 3 pillowcases available for use. There were no bed linens, towels or wash rags available for use. During an interview on 09/11/24 at 10:44 AM, CNA H said depending on the time they had to wait for clean linen to get back to them. CNA H said everything they had had been used that morning and they had to wait until sometime after lunch to get clean linen back. CNA H said she made it work in order to complete daily tasks. CNA H said the residents were not at risk of not receiving a shower as they will somehow make sure they got one. CNA H said they had not had any issues getting resident's clothes back. CNA H said if they did not have enough linen, she would personally go to the laundry to see what the issue was to fix it. During an observation on 09/11/24 at 10:49 AM revealed the clean linen cart on west A hall had only 3 fitted sheets and 2 gowns. There were no towels or wash rags available for use. During an observation on 09/11/24 at 10:50 AM revealed the clean linen cart on east A hall only had 5 flat sheets, 3 incontinent pads, and 3 socks. There were no clean towels or wash rags available for use. During an observation on 09/11/24 at 10:52 AM revealed the clean linen cart on hall C had only 4 flat sheets. There were no clean towels, wash rags, flat sheets, or pillowcases available for use. During an observation on 09/11/24 at 11:00 AM revealed the clean linen cart in the secured unit of the facility had plenty of bed linen and gowns and only 5 towels and 8 wash rags. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/11/24 at starting at 4:02 PM, there were no towels or wash rags noted in the clean linen closets or the clean linen carts for hall A west, hall A east, hall B and hall C. There were only 3 towels and 3 wash rags noted in clean linen cart located in the secure unit. Therefore, only 3 towels and 3 wash rags were available for use for the entire facility for the rest of the day and night. During an observation and interview on 09/11/24 at 4:10 PM, the Housekeeping/Laundry Supervisor said the laundry staff for the day had clocked out at 3 PM. She said there was no one scheduled for the rest of the day to complete the laundry. The Housekeeping/Laundry Supervisor said she observed the laundry staff deliver clean linen to the linen closets before they left for the day. She said the aides were hiding linen in the resident's rooms and closets. The Housekeeping/Laundry Supervisor said she ordered bath linen monthly sometimes twice a month. She said the aides tend to throw them away or they were destroyed. The Housekeeping/Laundry Supervisor said she had her hands tied and could not do anything because of the laundry PPD only allowed her 1.4 employees a day or 10.92 hours for a census of 78. The Housekeeping/Laundry Supervisor said she was responsible for ensuring the facility had clean linens available for use and failure to have any could place the residents at risk for not receiving their showers or baths. The laundry was observed and there were only 2 clean towels available on the clean side. There were 13 bags of dirty linen on the floor on the dirty side as well as a large bin 3 feet wide of dirty clothes piled approximately 3 feet tall, and a pile of dirty clothes/linen on the floor next to the washer that was approximately 2 feet tall x 2 feet wide. During an interview on 09/11/24 at 4:26 PM, the Administrator said he expected the facility to have towels and wash cloths available for use and failure to provide any clean towels or wash rags placed the residents at risk for not obtaining their showers as assigned or requested. The Administrator said it was the Housekeeping/Laundry Supervisor who was responsible of making sure there was clean towels and wash rags available for use. Record review of the facility's policy Supplies and Equipment, Environmental Services revised February 2009, indicated . Housekeeping/laundry department supplies, and equipment shall be readily available do that department personnel can perform necessary tasks. 1. Equipment must be ready for use at all times of the day and night to serve the residents' needs. Care should be exercised in the handling and in the use of our equipment to prevent damage or breakage .

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	675668	A. Building B. Wing	09/11/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 4 of 4 residents (Resident #'s 10, 46, 73, and 182) reviewed for grievances. The facility failed to appropriately resolve Resident #46, Resident #182, Resident #73 and Resident #10's grievances when issues with missing clothing from continued from May 2024 to September 2024. This failure could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Record review of Resident #46's face sheet dated 09/11/24, indicated an [AGE] year-old male who admitted to the facility on [DATE] and readmitted [DATE]. Resident #46 had diagnoses of anxiety, unspecified psychosis (mental disorder characterized by disconnection from reality), depression (persistent depressed mood), and Alzheimer's disease (progressive disease that destroys memory and other mental functions). Record review of Resident #46's quarterly MDS assessment dated [DATE], indicated he was rarely/never understood and rarely/never understood others. The MDS assessment indicated Resident #46 had short-term and long-term memory problems. The MDS assessment indicated Resident #46 required substantial/maximal assistance with oral hygiene, toileting, dressing, personal hygiene, sit to stand, chair/bed-to-chair, toilet transfer, and tub/shower transfer. Resident #46 was totally dependent with showers. The MDS assessment indicated Resident #46 was always incontinent of bowel and bladder. Record review of Resident #46's comprehensive care plan dated 06/12/24, indicated Resident #46 was incontinent of bowel and bladder. The care plan interventions indicated to provide incontinence care after each incontinent episode. During an interview on 09/09/24 at 2:45 PM, Resident's # 46's family member said their major concern with the facility was the residents clothing coming up missing. Resident #46's family member said Resident #46 had lost 4 wardrobes of clothes since he admitted to the facility. Resident #46's family member said he had reported it the someone in the office but unable to recall who. Resident #46's family member said he stopped telling the staff since they never find the stuff. Resident #46's family member said when the facility called him regarding Resident #46 not having any more clothes, he just usually went to the store and bought him more. Resident #46's family member said it was getting costly trying to replace all the missing clothing. Record review of the grievance file on 09/10/24 did not indicate a grievance was completed for Resident #46's missing clothing in the last 12 months. During an interview on 09/11/24 at 9:51 AM, LVN K said she had not received a grievance on Resident #46 missing clothing. LVN K said if she received a complaint of missing clothing, she would try to locate the missing items. If she could not locate them, she would report it the DON or Administrator. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #73's face sheet dated 09/11/24, indicated a [AGE] year-old male who admitted to the facility admitted to the facility on [DATE] with diagnoses which included dementia (memory loss) with agitation, anxiety, schizoaffective disorder, bipolar type (a mental health disorder characterized by symptoms of both schizophrenia (hallucination and delusions) and mood disorder), and essential hypertension (high blood pressure). Record review of Resident #73's quarterly MDS assessment dated [DATE], indicated Resident #73 rarely/never understood made himself understood and rarely/never understood others. The MDS assessment indicated Resident #73 had short-term and long-term memory problems. The MDS assessment indicated Resident #73 required substantial/maximal assistance with oral hygiene, toileting, showering, dressing, and personal hygiene. The MDS assessment indicated Resident #73 was always incontinent of bowel and bladder. Record review of Resident #73's comprehensive care plan dated 05/10/24, indicated Resident #73 was incontinent of bowel and bladder. The care plan interventions indicated to provide incontinence care after each incontinent episode. Record review of Resident #73's grievance form dated 07/08/24, indicated [resident's family member] stated that she had to go home to get her husband more clothes. She does not want laundry to wash his clothes anymore as he does not get them back. The grievance official follow-up documented by the Housekeeper/Laundry Supervisor indicated, At the time we were 18 bags behind went to laundry mat to catch up. The grievance form indicated the grievance was resolved on 07/7/24. The grievance form did not indicate if Resident #73's clothes was found and returned to him. During an interview on 09/11/24 at 9:13 AM, Resident #73's family member said she visited her husband weekly. Resident #73's family member said she would ask the staff when she did not see his clothing. Resident #73's family member said the staff would tell her it was in the laundry. Resident #73's family member said she would go purchase more clothing for her husband and the next time she visited his clothing was not there. Resident #73 said staff told her once the washing machine was broken. Resident #73's family member said her husband was a person and wanted him in his clothes and not a gown. Resident #73 said she spoke to the Administrator and when she came back 2 weeks later and most of his clothes was back. Resident #73's family member said she informed the facility staff she would do Resident's #73's laundry as she could not afford to keep buying him more clothes. Record review of Resident #182's face sheet dated 09/11/24 indicated a [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE]. Resident #182 had diagnoses of Alzheimer's disease (a group of symptoms that affects memory, thinking and interferes with daily life), ventricular fibrillation (an abnormal heart rhythm in which the ventricles of the heart quiver), and osteoarthritis (degenerative joint disease that results from breakdown of joint cartilage and underlying bone). Record review of Resident #182's quarterly MDS assessment dated [DATE], indicated Resident #182 was rarely/never understood and rarely/never understood others. The MDS assessment indicated Resident #182 had short-term and long-term memory problems. The MDS assessment indicated Resident #182 was dependent on staff with eating, oral hygiene, toileting, showering, lower body dressing, and personal hygiene. The MDS assessment indicated he was always incontinent of bowel and bladder. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #182's comprehensive care plan dated 07/05/24, indicated Resident #182 was incontinent of bowel and bladder. The care plan interventions indicated to provide incontinence care after each incontinent episode. Record review of Resident #182's grievance form dated 05/29/24, indicated Resident 183'2 family member complained of Resident #182's missing clothes- warmups (4); other t-shirts, some solid, some print; 2 blankets, fleece; socks-dark colored gray and Resident #182 being asleep on mattress with no sheets. The grievance from under follow-up documented by the Housekeeping/Laundry Supervisor indicated Laundry extremely backed up due to washer down/1 employee down and power out due to storms. The grievance report indicated the date resolved was 05/29/24. The grievance report did not indicate if Resident #182's missing personal items were found and returned to him. During an interview on 09/11/24 at 9:38 AM, Resident 182's family member said Resident #182 had since passed away. Resident #182 said at the time of Resident #182's passing he was still missing clothes. Resident #182's family member said her only request was for the residents clothing to be washed and replaced in a timely manner. Resident #182's family member said she had spoken to the Administrator regarding Resident 182's missing clothes. Resident #182's family member said the facility staff tried to locate his missing clothes and at one point had asked them to bring more clothing. Resident #182's family said they decided to do Resident #182's laundry so his clothing would not come up missing. During an interview on 09/10/24 at 9:42 AM, the Housekeeping/Laundry Supervisor said she was responsible for all facility laundry. The Housekeeping/Laundry Supervisor said she had received complaints of missing laundry. She said sometimes they were unable to find the missing clothing, but the family and residents have been understanding. The Housekeeping/Laundry Supervisor said sometimes clothes had been taken when a resident passed away since some residents shared closets with their roommates. The Housekeeping/Laundry Supervisor said she had her hands tied and could not do anything because of the laundry PPD only allowed her 1.4 employees a day or 10.92 hours for a census of 78. The Housekeeping/Laundry supervisor said she had only one employee in the laundry for an 8-hour shift and was unable to keep up with the laundry. During an interview on 09/11/24 at 1:50 PM, the SW said she handled the grievances. She said when she received a grievance, she gave it to the supervisor of that department to handle it. The SW said she had not received a grievance on Resident #46 but had received grievances on Resident #73 and Resident #182. The SW said Resident #73's and Resident #182's grievances did not indicate if their missing items were found so the grievance was not resolved. The SW said there had been issues with the laundry about being backed up and backed up and have not been able to keep up for a while. The SW said it was her responsibility for ensuring the grievance was resolved. The SW said she expected the laundry to have at least a 2 day turn around, but more than 2 days was unacceptable. During an interview on 09/11/24 at 2:22 PM, the DON said the SW was responsible for overseeing the grievances. The DON said once a grievance was received, they had to reach a resolution within 72 hours and the resident or family member was notified of the findings. The DON said they had issues with the delay in laundry. The DON said she had not received a grievance on Resident #46's missing clothes. The DON said Resident #73's and Resident #182's grievances did not indicate if the clothes were found. The DON said since there were continued complaints of clothing missing the grievances were not resolved. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/24 at 3:00 PM, the Administrator said he had not received a grievance on Resident #46's missing clothes. The Administrator said Resident #73's and Resident #182's grievances were resolved. The Administrator said when they received a grievance about missing clothes, they search the building and if clothing was not found they would replace them. The Administrator said the grievance form should have had if the clothing was found and returned to the resident. 45879 Record review of Resident #10's face sheet, dated 09/11/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), Diabetes (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly, resulting in high blood sugar levels), and Depression (sadness). Record review of Resident 10's quarterly MDS assessment, dated 08/09/24, indicated Resident #10 was usually understood and was usually understood by others. Resident #10 had a BIMS score of 15 indicating she was cognitively intact. The MDS indicated Resident #10 required total or extensive assistance with her ADLs and set-up with eating. The MDS indicated she was incontinent of bowel and bladder. Record review of Resident 10's comprehensive care plan dated 08/16/24 indicated Resident #10 was incontinent of bowel and bladder. The intervention was for staff to provide incontinent care after each incontinent episode. During an interview on 09/10/24 at 9:13 a.m., Resident #10 said she had been missing her clothes and they had not been replaced. She said she was missing several pairs of pants and shirts. She said her mother was aware and was going to replace them. Record review of the grievances for February 2024 through September 2024 did not indicate a grievance for Resident #10's shirts or pants. During an interview on 09/10/24 at 2:55 p.m., the SW said any staff could take a grievance. She said once she received the grievance, she would give it to the department that needed to oversee the grievance. She said then she would bring the grievances to morning meetings and follow up on any grievances. She said once the department returned the grievance, she placed it in her book. She said she did not look over the grievance but assumed once the grievance was given to her it was resolved She looked at the form and said the ADM was supposed to fill out the bottom, but he had not on the grievances we looked at. She said she did not remember any grievance on Resident #10. During a phone interview on 09/11/24 at 9:22 a.m., the RP of Resident #10 who said she was missing about 21 pairs of pants and 22 tops. She said she came to the facility after Resident #10 called her and looked in her closet and her clothes were missing. She said she came and talked with the Administrator, and he said he would look for them. She said that was about 3 weeks ago and had not heard back from them. She said she was also missing about 20 pairs of socks. She said they had been putting Resident #10 in her roommate's clothes because she did not have any in her closet. She said all of Resident #10's clothes and socks were marked with her name. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/24 at 10:15 a.m., the Administrator said any staff or family member could fill out a grievance. He said staff were aware of the grievance and they could hand one to a family member after hours and place it in the grievance box outside of his office. He said when a grievance was taken, they gave it to the SW, and she would then give it to the department in which the grievance was concerned. He said he was not aware of Resident #10 missing any clothes or family coming to talk with him about the missing clothes. During an interview on 09/11/24 at 4:48 p.m., the DON said the SW was the person who managed the grievance, and the Administrator was the overseer. She said she was not aware of Resident #10's missing clothes. During an interview on 09/11/24 at 4:48 p.m., the Administrator said he did not remember talking to Resident #10's family about her missing clothes. He said he was ensuring the grievance had been resolved by signing the bottom of the grievance form. Record review of the facility's policy Resident Rights revised February 2021 reflected . 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to . u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; 4. have the facility respond to his or her grievances . Record review of the facility's policy Grievances, Recording and investigating revised 01/12/23, reflected . All grievances filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s) . 2. The Administrator or designee will assign the responsibility of investigating the grievance . 6. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 3 working days of the filing of the grievance .

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	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 21 residents (Residents # 46), reviewed for care plans. The facility failed to revise Resident #46's care plan after he fell on [DATE], 07/12/2024, and 08/25/2024. This failure could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of Resident #46's face sheet dated 09/11/24, indicated an [AGE] year-old male who admitted to the facility on [DATE] and readmitted [DATE]. Resident #46 had diagnoses of anxiety, unspecified psychosis (mental disorder characterized by disconnection from reality), depression (persistent depressed mood), and Alzheimer's disease (progressive disease that destroys memory and other mental functions). Record review of Resident #46's quarterly MDS assessment dated [DATE], indicated he was rarely/never understood and rarely/never understood others. The MDS assessment indicated Resident #46 had short-term and long-term memory problems. The MDS assessment indicated Resident #46 required substantial/maximal assistance with oral hygiene, toileting, dressing, personal hygiene, sit to stand, chair/bed-to-chair, toilet transfer, and tub/shower transfer. Resident #46 was totally dependent with showers. The MDS indicated Resident #46 had 2 falls with no injuries and 1 fall with injury since prior MDS assessment . Record review of Resident #46's comprehensive care plan edited on 09/09/24, indicated Resident #46 had a history of falling related to memory deficits including Alzheimer's disease, history of stroke, and encephalopathy (brain disease that alters brain function and structure). The care plan interventions dated 06/14/24, indicated to give resident verbal reminders not to ambulate/transfer without assistance, keep bed in lowest position with brakes locked, keep call light in reach at all times, and keep personal items and frequently used items within reach. The care plan did not indicate the interventions implemented after Resident #46's falls on 07/09/2024, 07/12/2024, and 08/25/2024. Record review of Resident #46's event report dated 07/09/24, indicated Resident #46 was found on the floor in a seated position in his room. The report indicated Resident #46 sustained a laceration on his left elbow and right hand. The report indicated the interventions taken was to continue padded floor mat. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #46's event report dated 07/12/24, indicated Resident #46 was found on the floor in a lying position on the side of the bed with no injuries observed. The report indicated the interventions taken had other-assessment checked. The report indicated under outcome on interventions had no interventions used. Record review of Resident #46's event report dated 08/25/24, indicated Resident #46 had a witnessed fall in the day room with no injures observed. The event report indicated Resident #46 slid to the floor when the aide was attempting to transfer Resident #46 to his wheelchair. The report indicated the interventions taken had other-assessment checked. Under outcome on interventions, had no interventions used. During an observation on 09/09/24 at 11:38 AM, Resident #46 was sitting in the recliner in the living room of the secure unit. During an observation on 09/10/24 at 8:18 AM, Resident #46 was sitting in the recliner in the living room of the secure unit. During an interview on 09/11/24 at 10:38 AM, LVN K said Resident #46 had the following interventions in place: low bed, fall mat by his bed and was monitor regularly. LVN K said since she was an agency nurse, she did not update the residents care plans. LVN K said the interventions should be on the resident's care plan for staff to know what was put in place to decrease Resident #46's falls. During an interview 09/11/24 at 2:04 PM on the ADON said the interventions put in place for Resident #46 were the following: low bed, fall mat, when out of bed resident in common area, nonskid socks or appropriate footwear, call light within reach and anticipate needs . The ADON said she was responsible for updating the care plans. The ADON said she expected the nurses to put an intervention in place when a resident had a fall until someone in management arrived at the facility. The ADON said by not updating Resident #46's care plan with the interventions put in place would place Resident #46 at risk for continued falls. During an interview on 09/11/24 at 2:22 PM, the DON said the interventions put in place for Resident #46 were the following: therapy screen, medication review, low bed, and fall mat. The DON said she expected Resident #46's fall interventions to be updated in Resident #46's care plan. The DON said failure to update the care plan would cause the staff not have the latest information and place Resident #46 for continued falls. The DON said the ADON and herself were responsible for updating the care plans. During an interview on 09/11/24 at 3:00 PM, the Administrator said he expected the care plans to be updated as needed so staff was aware of the treatment plan. The Administrator said the DON or designee were responsible for ensuring the care plans were updated. The Administrator said failure to update Resident #46's care plan would place Resident #46 at risk for continued falls as staff would be unaware of the interventions put in place to decrease him from falling. Record review of the facility's policy Comprehensive Care Plans revised 01/26/24, reflected . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment. The comprehensive care plan will include measurable objective and timeframes to meet the residents needs as identified in the resident comprehensive assessment .

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	675668	A. Building B. Wing	09/11/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observation, interview and record review the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 21 residents (Resident #59) reviewed for ADL (activities of daily living) care. The facility failed to provide facial hair removal/shaving for dependent female Resident #59 on 09/09/2024. This failure could place residents at risk of not receiving care and services to meet their needs. Findings include: Record review of the face sheet, dated 09/11/2024, revealed Resident #59 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included Encephalopathy unspecified (damage or disease that effects the brain), Schizophrenia, unspecified, (affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior. Hallucinations involve seeing things or hearing voices that aren't observed by others), bipolar disorder, unspecified (mental health condition that causes extreme mood swings). Record view of the MDS, dated [DATE], revealed Resident # 59 had a BIMS of 13 (mildly impaired). Resident #59 required moderate assistance of one person for dressing, bathing, and personal hygiene ADLs. The MDS revealed Resident #59 did not reject care or evaluation. Record review of care plan, with a revision date of 07/06/2024, indicated Resident # 59 has an ADL self-care performance deficit. Care plan goals included maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. The care plan interventions include, Resident # 59 requires extensive assist of one staff. During an observation on 09/09/2024 at 9:15 a.m. Resident # 59 was observed with chin hair approximately 3-4 (cm) in length. Resident # 59 stated the chin hair made her feel bad and wanted it removed. During an observation on 09/10/2024 at 8:13 a.m. Resident # 59 was observed with chin hair approximately 3-4 (cm) in length. During an observation on 09/11/2024 at 8:30 a.m. Resident # 59 was observed with chin hair approximately 3-4 (cm) in length. During an interview on 09/11/2024 at 1:12 p.m. CNA F stated he did not notice Resident # 59's had hair on her chin. CNA F stated he would offer to groom them during their shower. CNA F stated the importance of removing Resident #59's chin hair was because she was a woman, and it could make her feel self-conscience. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/2024 at 1:21 p.m. with LVN B stated she noticed hair on Resident # 59 chin. LVN B stated she would ask Resident #59 if she wanted it removed. LVN B stated the importance was dignity. LVN B stated the harm to the resident was another resident could make fun of her. During an interview on 09/11/2024 at 1:56 p.m. the ADON stated CNAs are responsible for facial hair removal during showers. The ADON stated it was important for the resident's dignity. The ADON stated Resident # 59's facial hair could negatively affect her daily living. The ADON stated she would have an in-service with the CNAs. During an interview on 09/11/2024 at 2:05 p.m. with DON stated CNAs were expected to do the task of facial hair removal and this should be offered during shower time. The DON stated it was her responsibility to monitor the CNAs, however all of management do daily rounds to monitor. The DON stated the importance of removing facial hair was dignity and could affect Resident # 59's self-esteem. The DON stated she would do an assessment and follow up with Resident # 59. During an interview on 09/11/2024 at 2:20 p.m. the Administrator stated he expected the CNAs to ensure female residents don't have hair on their chin. The Administrator stated it was the responsibility of the nurses to monitor the CNAs. The Administrator stated he would do daily rounds to look at each resident. The Administrator stated it was important for Resident #59's emotional wellbeing if she did not want facial hair. Record review of the facility's policy titled Activities of Daily Living dated 3/2018, Appropriate care and services would be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care)

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	675668	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 1 of 21 residents reviewed for laboratory services (Residents #46). The facility failed to obtain ordered Depakote level (level obtained to ensure medication is in therapeutic range) for Resident #46. This failure could place residents at risk of not receiving timely diagnoses, treatment, and services to meet their needs. Findings included: Record review of Resident #46's face sheet dated 09/11/24, indicated an [AGE] year-old male who admitted to the facility on [DATE] and readmitted [DATE]. Resident #46 had diagnoses of anxiety, unspecified psychosis (mental disorder characterized by disconnection from reality), depression (persistent depressed mood), and Alzheimer's disease (progressive disease that destroys memory and other mental functions). Record review of Resident #46's quarterly MDS assessment dated [DATE], indicated he was rarely/never understood and rarely/never understood others. The MDS assessment indicated Resident #46 had short-term and long-term memory problems. The MDS assessment indicated Resident #46 required substantial/maximal assistance with oral hygiene, toileting, dressing, personal hygiene, sit to stand, chair/bed-to-chair, toilet transfer, and tub/shower transfer. Resident #46 was totally dependent with showers. Record review of Resident #46's lab result dated 06/25/24, indicated Resident #46's level was 36.0 which indicated the level was low. Record review of Resident #46's lab order dated 07/25/24 indicated Depakote level once with a start date of 07/29/24. Record review of Resident #46's progress note dated 07/25/24 at 11:56 AM, signed by the ADON, indicated [nurse practitioner's name] with [the psychiatric company] in facility; new order reduce Depakote 125mg to 3 tabs twice a daily and draw Depakote level on Monday 07/29/24 . Record review of Resident #46's lab result dated 08/30/24, indicated Resident #46's level was 36.9 which indicated the level was low. Record review of Resident #46 physician order report dated 08/11/24-09/11/24, indicated Resident #46 had an order for Depakote Sprinkles 125mg give 4 capsules twice a day for unspecified psychosis with a start date of 08/26/24. Record review of Resident #46's medication administration dated 08/11/24-09/11/24, indicated Resident #46 received Depakote sprinkles 125mg 4 capsules twice a day since it was increased on 08/26/24. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #46's electronic medical record on 09/11/24, did not reveal a lab result for Depakote level dated 07/29/24. During an interview on 09/11/24 at 02:04 PM, the ADON said she could not find the Depakote level that was ordered for 07/29/24. The ADON said could not find a lab requisition for 07/29/24 either. The ADON said Resident #46 did not have history of seizures and medication was given for a mood disorder. The ADON said when the nurse practitioner rounded, the orders were given to her, and she would instruct the nurses what needed to be completed. The ADON said Resident #46's Depakote level was checked for toxicity. The ADON said Resident #46 was not toxic in June or in August. The ADON said it was her responsibility to have ensured Resident #46's lab was obtained on 07/29/24 as ordered. The ADON said by not obtaining the lab as ordered Resident #46 was at risk for missed labs and toxicity. During an interview on 09/11/23 at 2:22 PM, the DON said she expected the labs to be obtained as ordered. The DON said Resident #46 was on Depakote for behavioral reasons, not for seizures and his lab was obtained to check for toxicity. The DON said the root cause of the problem was inconsistent nurse staffing since they had been using agency to staff nurse positions. The DON said she was ultimately responsible for ensuring the labs were obtained as ordered. The DON said they checked orders daily and was unsure how Resident #46's lab order was missed. The DON said they had a tracking tool they used and the ADON pulled the lab results every morning. During an interview on 09/16/24 at 03:00 PM, the Administrator said he expected the labs to be obtained as ordered unless they could not be obtained. The Administrator said not obtaining the lab as ordered placed Resident #46 at risk for toxicity. The Administrator said nursing was responsible for ensuring all labs were obtained as ordered. The Administrator said the nurse that obtained the order was responsible for completing the lab requisition. Record review of the facility's policy Lab and Diagnostic Test Results- Clinical Protocol revised September 2012, indicated . 1. The physician will identify, and order diagnostic and lab testing based on diagnosis and monitoring needs. The staff will process test requisitions and arrange for tests .

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	675668	A. Building B. Wing	09/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services, in that: 1) The facility failed to label and date all food items. 2) Dietary staff failed to dispose of expired foods items. 3) Dietary Staff failed to effectively reseal, label and date frozen food items. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During observations with [NAME] E on [DATE] beginning at 9:39 am, the following observations were made in the kitchen Refrigerator (1 of 1): -(1) 128 fluid ounce bottle of white vinegar had an open date of [DATE] and expiration date of [DATE]. (expired) -(1) gallon of tartar sauce had an open date of [DATE] and no expiration date. -(1) gallon of tartar sauce had an open date of [DATE] and no expiration date. -(1) sandwich bag of shredded carrots was not labeled, had no preparation date and no expiration date. -(1) gallon size bag of thawed bacon had a preparation date of [DATE]. (expired) During observations with [NAME] E on [DATE] beginning at 9:51 am, the following observations were made in the kitchen walk-in refrigerator (1 of 1): -(1) pitcher of tomato juice had a preparation date of [DATE]. (Expired) During observations with the [NAME] E on [DATE] beginning at 9:56 am, the following observations were made in the kitchen walk-in freezer (1 of 1): (1) unopened clear package of frozen chicken, had no label, no receive date and no expiration date. (1) clear package of frozen bread sticks, had no label, no open date, no receive date and no expiration date. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) clear package of frozen French fries was not sealed and not labeled. (1) unopened clear package of frozen French fries was not labeled. (1) frozen bag of pepperoni was not sealed. (1) frozen bag of tater tots was not sealed. (5) unopened bags of red potato wedges was not labeled. (22) frozen bags of prepared fresh peas was not labeled, had no preparation date and no expiration date. During observations with the [NAME] E on [DATE] beginning at 10:01 am, the following observations were made in the kitchen side by side refrigerator (1 of 1): (1) frozen box of 216 count biscuits was not sealed. During an interview on [DATE] at 9:44 a.m., [NAME] E stated she had been a cook at the facility for 5 years. [NAME] E stated she normally worked 5am to 1pm shift. [NAME] E stated her last in-service on labeling, dating and disposing of expired foods was conducted last month by the Dietary Manager. [NAME] E stated all staff were responsible for disposing expired foods. [NAME] E stated it was the dietary staff responsibility to check the refrigerator and freezer daily for labeling, dating and resealing freezer and refrigerated food items. [NAME] E stated the Dietary Manager conducted daily walk-thrus in the kitchen. [NAME] E stated in the past the Dietary Manager had found expired food items in the kitchen. [NAME] E stated the Dietary Manager was really strict on cleanliness. [NAME] E stated that she was unaware of the expired food items, the improperly sealed freezer items, and the unlabeled food found in both the freezer and refrigerator in the kitchen. [NAME] E stated the Dietary Manager oversaw her. [NAME] E stated, It was important to discard expired food items so the patients could not get the expired foods. During an interview on [DATE] at 9:57 a.m., the Dietary Manager stated she had been the Dietary Manager for 8 years at the facility. The Dietary Manager stated she worked the 6 a.m. to 3 p.m. shift. The Dietary Manager stated she pop in and out of the kitchen on weekends. The Dietary Manager stated she completed in-service on food storage, menu and substitutions and on personal items in the freezer. The Dietary Manager stated she conducted Monday thru Friday walk thrus. The Dietary Manager indicated that she was unaware of the expired food items, the improperly sealed freezer items, and the unlabeled food found in the freezer and refrigerator in the kitchen. The Dietary Manager stated the Administrator oversaw her. The Dietary Manager stated, It was important to ensure food was discarded because the expired food could grow bacteria and staff has to really monitor when to discard expired foods. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:06 a.m., the Administrator stated he had been the administrator since [DATE]. The Administrator stated he conducted walk-thrus in the kitchen on every blue moon. The Administrator stated he should conduct walk thrus in the kitchen once a week but did not conduct weekly walk thrus in the kitchen. The Administrator stated his last walk thru was conducted at the end of the month [DATE]. The Administrator stated that he was unaware of the expired food items, improperly sealed freezer items, and unlabeled food in the freezer and refrigerator until these issues were identified by the surveyor. The Administrator stated he oversaw the Dietary Manager. The Administrator stated, It was important to ensure staff were discarding expired foods to ensure the residents did not get bad food. Record Review of the facility's Dietary policy titled Food Storage dated 2018, indicated, 2. Refrigerators: (d) Date, label and tightly seal all refrigerated [NAME] s using clean, nonabsorbent, covered containers that are approved for food storage; (e) Use all leftovers within'72 hours, Discard items that are over 72 hours. (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	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of FDA Food code dated 2022 indicated, ,d+[DATE].11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents. (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.

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	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Memorial Nursing and Rehabilitation Center	320 Greenville Highway Mineola, TX 75773

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 3 of 4 residents (Resident #27, Resident #35, and Resident # 15) reviewed for hospice services. The facility failed to maintain Resident #27's, Resident #35's, and Resident #15's hospice binder containing information related to hospice services provided for the resident such as the most recent plan of care, hospice election form, physician recertification, and hospice medication profile. These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: 1. Record review of Resident #27's face sheet, dated 09/11/24 indicated he was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Anxiety (a feeling of fear, dread, and uneasiness), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), hypertension (high blood pressure), and Depression(sadness). Record review of Resident 27's significant change in status MDS assessment, dated 08/22/24, indicated Resident #27 was sometimes understood and was sometimes understood by others. Resident #27 had short and long-term memory loss indicating she was cognitively impaired. The MDS indicated Resident #27 required total or extensive assistance with her ADLs. The MDS indicated she was receiving hospice service. Record review of Resident 27's Physician order dated 08/22/24 revealed Resident #27 was admitted to hospice with a diagnosis of Alzheimer's Disease (a type of dementia). Record review of Resident #27's comprehensive care plan, dated 09/04/24, revealed Resident #27 was admitted to hospice for a diagnosis of Alzheimer's Disease. The intervention was for staff and hospice to communicate the resident's needs and work together to meet her needs while following the physician's orders. Record review of Resident #27's hospice binder did not have the Physician certification of the terminal illness, care plan, medication list, or Hospice election form. During an interview on 09/10/24 at 2:42 p.m., LVN E looked for Resident #27's binder and only saw a folder which contained a sign-out sheet for her visits. LVN E said she did not look at the hospice folder because they had all the information she needed on her computer. She said the hospice company was responsible for the upkeep of their folders or binders. She said hospice should have all the information for the resident such as meds and plan of care in the resident's folders or binders. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 09/11/24 at 8:57 a.m., the Hospice RN L said they recently acquired Resident #27 on their service. She said the only thing Resident #27 had at the facility was a folder that contained a sign-in sheet when a staff member came to visit. She said she had planned to drop the binder off at the facility before now, but she had not. She said the folder should contain her certification to be on hospice, her medication list, and her plan of care. She said they had an IDT meeting on 08/29/24. She said they meet every 2 weeks. She said she did not know who was responsible for getting the bi-weekly notes, etc., to the facility. She said it must be the office because she had never brought any paperwork to the facility on ce admitted . She said it was important to have the binders at the facility to help the facility know why the resident was admitted and to ensure we were providing the care she needed. She said she would drop off her binder today (09/11/24). 2.Record review of Resident #35's face sheet, dated 09/11/24 indicated she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Congestive heart failure (CHF), or heart failure, (a long-term condition in which your heart can't pump blood well enough to meet your body's needs), and anxiety (an emotion that can feel like a state of inner turmoil, dread, or uneasiness). Record review of Resident 35's annual MDS assessment, dated 07/12/24, indicated Resident #35 was understood and usually understood by others. Resident #35 BIMS score was a 15 indicating she was cognitively intact. The MDS indicated Resident #35 required assistance with his ADLs. The MDS indicated he was receiving hospice service. Record review of Resident 35's Physician order dated 04/05/24 revealed Resident #35 was admitted to hospice with a diagnosis of CHF. Record review of Resident #35's comprehensive care plan, the revision date of 07/18/24, revealed Resident #35 was admitted to hospice for a diagnosis of CHF. The intervention was for staff to treat the resident per physician orders and include the resident and her RP with any changes to her orders. Orientate the resident to her surroundings as much as possible and administer pain medications as ordered. Record review of Resident #35's hospice binder contained a recertification of terminal illness dated 07/22/23, the last IDT meeting and medication list was dated 07/19/24. Record review of Resident 35's Physician order per the facility dated 08/07/24 revealed Resident #35 had an order to cleanse stage 3 pressure wound to the left ischium with normal saline or wound cleanser, pat dry, apply collagen to the wound bed, apply calcium alginate, cover with silicone bordering dressing daily. The hospice medication list did not have this order. Record review of Resident 35's Physician order per the facility dated 09/06/24 revealed Resident #35 had an order to cleanse the wound to the left hip with normal saline or wound cleanser, pat dry, gently fill with packing strip, and cover with dry dressing daily. The hospice medication list did not have this order. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 09/11/24 at 10:38 a.m., the DON of [the hospice company] called and said the facility should have access to all their resident's EMRs. She said if the facility had its binders, the following information should be included: the legal information, plan of care, IDT meetings held every 2 weeks, and a sign-in sheet for the aides, the chaplain, and the nurses. She said the case manager was responsible for ensuring the paperwork was sent to the facility following the IDT meeting or any new certifications or changes. She said she had been employed with the hospice company a little over a month and had not had a chance to check with each nursing facility to see their process. She said she would have someone bring the updated paperwork to the facility today (09/11/24). During an interview on 09/11/24 at 1:34 p.m., LVN A said hospice usually brings the binders when they admit. The binders should contain the DNR, meds covered by hospice, a face sheet, and a sign-in sheet so we would know who had visited the resident. She looked through Resident #27's folder and did not see any information except a sign-in sheet. She said those things were important to have in the resident's binder because they provided easy access to meds, code status, and who had visited the resident. LVN A looked through Resident #35's binder and saw the last IDG meeting and orders were dated 7/19/24. She said she was not aware of any other place Resident #35's information could be except in her binder. She said the hospice companies were responsible for updating their binders. During an interview on 09/11/24 at 3:47 p.m., the ADON said the hospice companies were responsible for ensuring the hospice documents were being brought to the facility and were the most recent. The ADON said not having the most updated hospice documents at the facility could cause a resident to miss certain orders or treatments. During an interview on 09/11/24 at 4:11 p.m., the DON said she expected the hospice documents to be at the facility with the most recent plan of care and current medication orders. The DON said the failure to ensure those documents were at the facility was due to a lack of communication with the facility and the hospice companies. She said she was not aware of any hospice EMR access. The DON said it was the responsibility of the hospice company to ensure their documents were being brought to the facility timely and then it was the facility's responsibility to ensure that was being completed. The DON said there had not been any monitoring in place to ensure the hospice documents were being brought to the facility. She said the hospice binders help with medication changes and correlate care. During an interview on 09/11/24 at 4:48 p.m., the Administrator said it was the facility's responsibility to ensure all hospice documents were up to date. He said the ADON and DON were the overseers of the process. He said the books should be updated because they reflect the care the resident should be receiving. The Administrator said not having the most updated hospice documents including the plan of care with the current medication record, could cause the hospice company to send the wrong medication. Therefore, the residents could receive the wrong medication and cause a medication error. 46928 3. Record review of Resident #15's face sheet dated 09/11/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included dementia (memory loss) with agitation, senile degeneration of brain (mental deterioration), essential hypertension (high blood pressure), and glaucoma (a group of eye condition that causes blindness). (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's annual MDS assessment dated [DATE], indicated Resident #15 was rarely/never understood and rarely/never understood others. The MDS assessment indicated Resident #15 had short-term and long-term memory problems. The MDS assessment indicated Resident #15 received hospice care. The MDS assessment did not indicate Resident #15 received an antidepressant medication. Record review of Resident #15's comprehensive care plan dated 11/04/22, indicated Resident #15 had elected hospice care [hospice company] for terminal diagnosis of senile degeneration of brain. The care plan interventions indicated to coordinate care with hospice team and the hospice team to visit and perform care per schedule. Record review of Resident #15's hospice medication profile dated 02/27/24-04/26/24, indicated Resident #15 had the following orders that were not on her facility physician order summary report: *Escitalopram 5mg give on tablet for depression with a start date of 11/04/22. Record review of Resident #15's hospice care plan dated 05/16/24, indicated coordination of care needed to increase patient quality of care and quality of life. The care plan interventions included the social worker to communicate with facility staff, hospice team, patient and patient's family regarding patient status, care plans, family dynamics, and end of life issues. Record review of Resident #15's facility's physician order report dated 08/11/24-09/11/24, indicated Resident #15 had an order to admit to [hospice company] with diagnosis of senile degeneration of the brain with a start date of 05/07/24. The order report did not indicate Resident #15 had an order for escitalopram. Record review of Resident #15's hospice binder on 09/10/24 at 03:18 PM, indicated the following items: *Hospice medication profile dated 02/27/24-04/26/24 *Written certification dated 04/27/24-06/25/24 * Hospice IDG meeting dated 05/16/24. There was no election of hospice benefit form, the most recent plan of care or the most recent hospice medication profile noted in Resident #15's hospice binder or electronic medical record. Record review of Resident #15's order history report dated 05/01/24-09/11-24, indicated Resident #15's escitalopram was discontinued on 06/07/24. Record review of Resident #15's medication administration record dated 08/12/24- 09/11/24, indicated Resident #15 did not have orders for escitalopram or had received any. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/24, at 03:42 PM, the Hospice DON said Resident #15 had been on their hospice services since 11/03/22. The Hospice DON said updated hospice documents were brought to the facility every 2 weeks and placed in the hospice binder. The Hospice DON said the resident's care plan and updated medication were brought to the facility every 2 weeks and the hospice recertifications were brought to the facility every 60 days. The Hospice DON said Resident #15 was recertified for hospice services on 08/22/24. The Hospice DON said she printed Resident #15's hospice documents on 08/22/24 for the Hospice RN Case Manager to pick up the next morning but since the Hospice RN Case Manager was off last week the documents were not picked up. The Hospice DON said since the hospice documents were not updated, the Hospice RN Case Manager had probably not brought the documents to the facility. The Hospice DON said the Hospice RN Case Manager was responsible for ensuring the documents were brought to the facility every 2 weeks. The Hospice DON said failure to provide the facility with the most recent hospice documents was lack of coordination of care. The Hospice DON said they completed spot checks randomly at facilities to ensure the hospice documents were being updated. An attempted phone interview call was placed on 09/10/24 at 3:53 PM to Resident #15's Hospice RN Case Manager and was unsuccessful. During an interview on 09/11/24 at 02:22 PM, the DON said she expected Resident #15's most recent hospice documents to be at the facility for coordination of care. The DON said the hospice documents were a communication tool and failure to have the most recent was a lack of coordination of care with the hospice company. The DON said they did not have a full-time medical person at the facility. The DON said it was the hospice company providing the service to the resident and the facility's medical person's responsibility of ensuring the most recent hospice documents were being brought to the facility. During an interview on 09/11/23 at 03:00 PM, the Administrator said he expected the resident's hospice documents to be brought to the facility according to their hospice contract. The Administrator said failure to bring the most updated hospice documents to the facility was a lack of coordination of care with the hospice company. The Administrator said the hospice company was responsible for bringing the most recent documents to the facility and the DON was responsible for ensuring those documents were being brought. Record review of the facility's policy Hospice Program revised July 2017, indicated the facility was responsible for the following . obtaining the following information from the hospice: . 1) the most recent hospice plan of care specific to each resident; 2) hospice election form; 3) Physician certification and recertification of the terminal illness specific to each resident; . 6) Hospice medication information specific to each resident, 7) Hospice physician and attending physician (if any) orders specific to each resident .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 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 3 of 4 (Resident #35, Resident #60 and Resident #77) and 1 of 1 laundry room reviewed for infection control practices. 1. The facility failed to ensure the ADON and CNA D wore proper PPE when providing incontinent care and wound care to Resident #35 who was on enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident care activities. 2. The facility failed to ensure CNA C properly cleaned the genital area, changed gloves, and used hand hygiene before going from dirty to clean while providing incontinent care for Resident #60. 3.The facility failed to properly store the resident's clean clothes in the laundry room. 4. The facility failed to properly store dirty bed linen, bath linen and residents personal clothing in the laundry room. 5. The facility failed to ensure Resident #77's catheter bag was not lying on the floor. 6. The facility failed to ensure the clean linen cart was covered. These deficient practices could place residents at risk for infection due to improper care practices. Findings included: 1.Record review of Resident #35's face sheet, dated 09/11/24 indicated she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included pressure wounds (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body), Congestive heart failure(CHF), or heart failure, (a long-term condition in which your heart can't pump blood well enough to meet your body's needs), and anxiety (an emotion that can feel like a state of inner turmoil, dread, or uneasiness). Record review of Resident 35's annual MDS assessment, dated 07/12/24, indicated Resident #35 was understood and usually understood by others. Resident #35 BIMS score was a 15 indicating she was cognitively intact. The MDS indicated Resident #35 required assistance with his ADLs. The MDS indicated he was receiving hospice service. Record review of Resident 35's Physician order dated 04/10/24 revealed Resident #35 had an order to cleanse the wound to the sacrum with normal saline or wound cleaner, pat dry, apply collagen to the wound bed, apply calcium alginate, and cover with padded silicone bordered dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 35's Physician order dated 09/06/24 revealed Resident #35 had an order to cleanse the wound to the left hip with normal saline or wound cleanser, pat dry, gently fill with packing strip, and cover with dry dressing daily. Record review of Resident #35's comprehensive care plan, the revision date of 07/18/24, revealed Resident #35 was on enhanced barrier precautions. The intervention was for staff to wear PPE during high-contact patient care. Record review of Resident #35's comprehensive care plan, the revision date of 07/18/24, revealed Resident #35 had a stage 4 ulcer to her sacrum. The interventions were for staff to administer vitamins, multivitamins, vitamin C, Pro-stat, and minerals. Apply dressing per physician orders, minimize skin exposure to moisture, encourage water, and turn and reposition frequently. During an observation on 09/09/24 at 3:08 p.m., An enhanced barrier sign was noted on Resident #35's door. During an observation on 09/11/24 at 11:41 a.m., the ADON and CNA D were providing wound care to Resident #35 without the PPE gown needed for enhanced barrier precautions. During an observation on 09/11/24 at 11:52 a.m., CNA D was providing Resident #35 with incontinent care and did not have on her PPE gown needed for enhanced barrier precautions. During an interview on 09/11/24 at 11:53 a.m., the ADON said did not wear the proper PPE while doing wound care for Resident #35. She said she knew she was supposed to wear it but forgot. She said they were supposed to wear PPE to protect the residents and staff from spreading infection. She said she did an in-service on enhanced barrier precaution yesterday (09/10/24). She said she could not believe she did not wear the required PPE. During an interview on 09/11/24 at 12:02 p.m., CNA- D said she was supposed to wear gloves and a gown when providing Resident #35 with incontinent care and when she helped the nurse with wound care. She said PPE was supposed to be worn to protect the residents and staff. 2.Record review of Resident #60's face sheet, dated 09/11/24, indicated Resident #60 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #60 had diagnoses which included Cerebral Palsy (a group of disorders that affect a person's ability to move, balance, and posture), anxiety (an emotion that can feel like a state of inner turmoil, dread, or uneasiness), and depression(sadness). Record review of Resident #60's quarterly MDS assessment, dated 07/25/24, indicated Resident #60 usually understood and usually understood others. Resident #60's BIMS score was 12, which indicated she was moderately cognitively impaired. Resident #60 required total assistance with toileting, limited assistance with personal hygiene, transfer, dressing, bed mobility, and extensive assistance with eating. The MDS indicated she was occasionally incontinent of bowel and bladder. Record review of Resident #60's comprehensive care plan, dated 08/01/24, indicated Resident #60 experienced bowel and bladder incontinence related to Cerebral palsy and impaired mobility. The interventions were for staff to provide incontinent care after each incontinent episode and report any skin breakdown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/11/24 at 11:22 a.m., CNA C was performing incontinent care on Resident #60. CNA C explained what she was going to do. She applied her gloves, wiped the genital area twice with the same wipe, and then changed her gloves without hand hygiene. She then turned the resident #60 over and wiped her buttock. CNA C used the same dirty gloves she wiped her buttocks with and put on Resident #60's clean pants. During an interview on 09/11/24 at 12:06 p.m., CNA C said she did not realize she wiped more than one time while providing incontinent care for Resident #60. She said she should have wiped it one time, discarded the wipe, and got a new one. She said she did not hand hygiene when she applied new gloves and she did not change her gloves when going from dirty to clean. She said she was supposed to wipe only once and hand hygiene when going from dirty to clean to prevent infection control issues. During an interview on 09/11/24 at 3:47 p.m., the ADON said she expected staff to wear the proper PPE needed for the enhanced barrier. She said she knew she and CNA D should have worn gowns and gloves when doing wound care and assisting with incontinent care, but she forgot. She said it was important to wear PPE to protect the residents and staff from spreading infection. She said when performing incontinent care, she expected staff to wipe front to back and change gloves from clean to dirty to prevent the spread of infection. During an interview on 09/11/24 at 4:11 p.m., the DON said staff were supposed to wear PPE for enhanced barrier residents that had been identified as susceptible to infection such as residents with gastric tubes, Foley catheters, and wounds. She said staff were supposed to wear PPE to protect the residents and staff. She said the identified resident should have a sign placed on their door reading enhanced barrier and a cart hanging on the door with the supplies in it. She said she was the infection preventionist and was responsible for training on infection control. She said they have had several in-services on enhanced barriers and incontinent care and expected staff to follow the policy. She said she and the ADON were responsible for ensuring staff was following the policy. The DON said she expected the staff to wear PPE, remove their gloves from dirty to clean, and handwash in between. The DON said failure to properly clean hands, wear contaminated gloves, and not wear PPE with enhanced residents, could cause infection. During an interview on 09/11/24 at 4:48 p.m., the Administrator said he expected staff to perform incontinent care correctly. He said staff should clean their hands between dirty to clean. He said if a resident required enhanced barrier precautions, he expected staff to wear the proper PPE. He said the DON and ADON were the overseers of nursing. He said failure to wear PPE or provide handwashing could spread infection. 46928 3. During an observation and interview on 09/10/24 at 09:42 AM the facility's laundry room was observed. There was an office chair in the clean side of the facility's laundry room that had clean clothes piled on top and there were multiple clean items touching the floor. On the side of the laundry room that had the dirty linen, there was a stack of dirty bed linen, bath linen and resident clothing that was approximately 3 feet in height by 3 feet wide and was sitting directly on the floor in front of the washing machine. The Housekeeping/Laundry Supervisor said the clothes were not supposed to be touching the floor due to infection control. The Housekeeping Supervisor said it was her responsibility in ensuring the clothes was maintained off the floor. The Housekeeping/Laundry Supervisor said not properly storing clean and dirty linen placed residents at risk for infection. (continued on next page)

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	675668	A. Building B. Wing	09/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/24 at 02:04 PM, the ADON said clean clothes touching the floor was not considered clean. The ADON said dirty clothes on the floor was an infection control issue. The ADON said the Housekeeping/Laundry Supervisor was responsible for ensuring infection control was maintained in the laundry room. During an interview on 09/11/24 at 02:22 PM, the DON said clean clothes touching the floor and dirty clothes on the floor was an infection control issue. The DON said mold and mildew ruins the resident's clothes and harbor bacteria and smells. The DON said it was the Housekeeping/Laundry Supervisor's responsibility infection control was maintained in the laundry room. During an interview on 09/11/24 at 03:00 PM, the Administrator said clean clothing touching the floor in the laundry room was an infection control issue. The Administrator said he did not see an issue if there were dirty linen/clothes on the dirty side as that area of the laundry was considered dirty. The Administrator said the laundry aide, or the Housekeeping/Laundry Supervisor were responsible for ensuring there were no clothes touching the floor and maintaining infection control. 47612 4.Record review of face sheet, dated 09/11/2024, revealed Resident #77 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of pressure ulcer of sacral region (skin injury that occurs in the sacral region of the body, near the lower back and spine), neuromuscular dysfunction of bladder (occurs when nervous system or brain cannot properly communicate with the bladder), type 2 diabetes mellitus without complications (characterized by high levels of sugar in the blood), Record review of Quarterly MDS assessment, dated 06/10/2024, indicated Resident #77 had a BIMS score of 15, indicating Resident #77 was cognitively intact and understood others as well as being understood. The MDS revealed Resident #77 had indwelling catheter. The MDS revealed Resident #77 had no behaviors or rejection of care during the look-back period. The MDS revealed Resident #77 required supervision with a one-person assistance for dressing, toilet use, and personal hygiene. Record review of comprehensive care plan, last revised on 07/11/2024, revealed Resident #77 had an indwelling catheter. Care plan goals included, resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma, The care plan interventions included catheter care per physician orders, keep catheter system closed as much as possible, manipulate tubing as little as possible during care, position bag below level of bladder, use catheter strap. During an observation on 09/09/2024 at 1:52 p.m., Resident #77 bed was positioned low to the floor and the catheter bag was lying on the floor. During an observation on 09/10/2024 at 9:09 a.m., Resident #77 bed was positioned low to the floor and the catheter bag was lying on the floor. During an observation on 09/11/2024 at 9:36 a.m., CNA F stated it was the CNAs responsibility to make sure the catheter bag was placed correctly on the bed rail. CNA F stated it was important to prevent bacteria from going up the tubing. CNA F stated the risk to the resident was infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 09/11/2024 at 10:40 a.m., LVN G stated all the staff was responsible for ensuring Resident #77 catheter [NAME] was not lying on the floor. LVN G stated it was important to keep the catheter bag off the floor to prevent cross contamination. LVN G stated the risk to Resident #77 was infection. During an interview on 09/11/2024 at 1:56 p.m., the ADON stated it was the nursing staff's responsibility to ensure the catheter was not lying on the floor. The ADON stated it was important to keep the catheter bag off the floor because it was an infection issue. The ADON stated she would monitor daily and make adjustment to Resident #77 bed, so the catheter was not on the floor. The ADON stated the failure could be cross-contamination and infection. During an interview on 09/11/2024 at 2:05 p.m., the DON stated she expected the nursing staff to ensure Resident #77 catheter bag was not lying on the floor. The DON stated it was important to keep the catheter bag off the floor to prevent infection. The DON stated she would hold an in-service and monitor daily. During an interview on 09/11/2024 at 2;.20, the Administrator stated he expected the CNAs to ensure Resident # 77 catheter bag was not lying on the floor. The Administrator stated it was important for infection control. The Administrator stated he would monitor by doing daily Angel rounds. 5. During an observation on 09/11/2024 at 1:00 p.m., linen cart sitting on hall C with cover was open. During an interview on 09/11/2024 at 1:10 p.m., CNA D stated the linen cart cover should be closed. CNA D stated it was important to keep the cover closed so the residents could not contaminate the supplies on the cart. CNA D stated the failure was cross contamination. During an interview on 09/11/2024 at 1:28 p.m., LVN A stated the linen cart cover should be closed. LVN A stated the charge nurse was responsible for ensuring the CNAs keep the cover closed. LVN A stated it was important to keep cover closed to keep supplies free from bacteria and germs. LVN A stated the failure was infection control. During an interview on 09/11/2024 at 1:56 p.m., the ADON stated she expected the staff to close the cover to the linen cart when not being used because that was part of infection control. The ADON stated it was her responsibility to monitor. The ADON stated it was important to keep the cover closed for infection control. The ADON stated she would in-service so staff would know to keep the cover closed. During an interview on 09/11/2024 at 2:05 p.m., the DON stated it was the CNAs responsibility to close the cover to the linen cart. The DON stated it was important to close the linen cart cover to keep the supplies free of germs. The DON stated she would in-service the staff and make daily rounds to monitor. During an interview on 09/11/2024 at 2:20, the Administrator stated he expects the staff to close the linen cart cover. The Administrator stated it was the responsibility of the nurse to monitor that the CNAs were closing the cover. The Administrator stated it was important to close the cover for infection control. The Administrator he would monitor during morning rounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Handwashing/Hand Hygiene, dated 1/20/23 indicated, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Hand hygiene must be performed prior to donning and after doffing gloves. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. Record review of the facility policy titled, Perineal Care, dated 1/20/23 indicated, Policy Statement: Perineal Care is providing cleanliness and comfort to the resident, preventing infections, skin irritation, and to observe the resident's skin condition. The following equipment and supplies needed included but are not limited to the following: 3. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure 1. Introduce self to resident and explain care that will be provided. 3. Perform hand hygiene and don gloves. 4. Arrange the supplies so they can be easily reached. 12. Remove gloves and discard into designated container. 13. Perform Hand Hygiene. 14. Reposition the bed covers. Make the resident comfortable. 15. Place the call light within easy reach of the resident. 16. Perform Hand Hygiene. Record review of the facility policy titled, Enhanced Barrier Precautions, dated 04/01/24 indicated, Policy Statement: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistance organisms. Policy Interpretation and Implementation: 1. Prompt recognition of need: A. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: I. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with an MDRO.3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing an activity with a risk of splash or spray (i.e., wound irrigation, tracheostomy care).4. High-contact resident care activities include: a. Dressing; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes; and h. Wound care: any skin opening requiring a dressing.9. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Record review of the facility's policy Laundry and Bedding, Soiled revised April 2020, indicated . Soiled laundry/bedding shall be handled, transported, and processed according to best practices for infection prevention and control. 1. All laundry is handled as potentially contaminated unit it is properly bagged and labeled for appropriate processing. A. soiled laundry and bedding (e.g., personal clothing, uniforms, scrub suits, gowns, bed sheets, blankets, pillows, towels, etc.) contaminated with blood or other potentially infectious materials is handled as little as possible and within a minimum of agitation . Record review of the facility's undated policy titled Indwelling Catheter Use and Removal securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and position below the bladder (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Infection Prevention and Control Program date 07/2024 A system for handling, storing, processing and transporting linens so as to prevent the spread of infection