STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675924	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Rehabilitation and Healthcare Center	7801 Woodway Dr Waco, TX 76712

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their written policies and procedures regarding investigating abuse for two (Resident #1 and Resident #2) of five residents reviewed for abuse and neglect. The facility failed to ensure a thorough investigation was completed by the abuse coordinator after an allegation of abuse was made on 10/11/2025 by Resident #2. This failure could place residents at risk of abuse, trauma, and psychosocial harm. Findings included:Review of Resident #1's comprehensive MDS assessment, dated 09/10/2025, reflected a [AGE] year-old male, admitted [DATE]. His diagnoses included progressive neurological conditions (gradual decline in neurological function), diabetes mellitus (chronic condition that affects how your body processes blood sugar), Alzheimer's disease (memory impairment), seizure disorder (abnormal electrical activity in the brain), anxiety (feelings of worry, fear, or unease), depression (persistent feeling of sadness), and psychotic disorder (severe mental health conditions). His BIMS score was a 3, indicating severe cognitive impairment. Review of Resident #1's care plan, dated 9/28/25, revealed he was care planned for having a behavior problem of wandering with interventions of, Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.Review of a nursing incident/accident investigation worksheet, dated 10/10/25 by agency LVN A, revealed that on 10/10/25 at 2:15 p.m. physical aggression was initiated by Resident #1 and there was resident to resident contact. Under the investigation summary section, it was indicated that the resident did not say what happened, the staff did not know what caused the incident, and there were no witnesses. The statement also reflected, When staff arrived at D/R this resident [Resident #1] had the other resident [Resident #2] on the floor-holding him down. The other resident [Resident #2] was noted lying on the floor with his shoulders up-trying to release himself from the resident.Review of Resident #1's progress note, dated 10/10/25, documented by agency LVN A revealed, Nurse and medication aide heard resident calling out for Help When we arrived at the d/r this resident had the other resident on the floor holding him down. The other resident was noted lying on the floor with his shoulders up-trying to release himself from the resident. No apparent injuries noted to RESIDENTS. NP was informed via phone with orders for U/A. Psych NP here with new orders: Depakote and Hydroxyzine-See Orders.Review of Resident #1's progress note, dated 10/23/25, revealed he was admitted to a behavioral health inpatient facility.Review of Resident #2's quarterly MDS assessment, dated 09/01/25, reflected a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included: heart failure, renal failure (medical condition in which the kidneys can no longer filter waste products from the blood), diabetes mellitus (chronic condition that affects how your body processes blood sugar), non-Alzheimer's dementia, anxiety (feelings of worry, fear, or unease), depression (persistent feeling of sadness), insomnia (inability to sleep), and malnutrition. His BIMS score was a 4, indicating severe cognitive impairment. Review of Resident #2's care plan, dated 9/12/25, revealed he was care planned for the potential to be physically aggressive when he pushed another resident on 1/25/25. His interventions included monitoring for agitation, redirection, give the resident choices, and to intervene before agitation escalates. Review of the facility's incident/accident reports from the last three months revealed an incident occurred on 10/10/25 where physical aggression was received by Resident #2, and physical aggression was initiated by Resident #1. Review of a nursing incident/accident investigation worksheet, dated 10/10/25 by agency LVN A, revealed that on 10/10/25 at 2:15PM Physical Aggression was received by Resident #2 and there was resident to resident contact. Under the investigation summary section, it was indicated that the resident said, I don't know why he just walked up and hit me., and the staff did not know what caused the incident, and there were no witnesses. It indicated the resident was not injured. It also revealed a staff statement, Staff heard residents calling for HELP When staff arrived at D/R resident was on the floor-and the other resident was noted holding him down. Resident was noted lying on the floor with his shoulders up-trying to release himself from the residentReview of a typed document on a piece of paper provided to the surveyor by the DON and VPHR revealed: [Resident #2] and [Resident #1]Completed by [previous ADM], 10.10.25Staff heard a cry for help and went to dining room. Found [Resident #2] on the floor with [Resident #1] holding his shoulders. No staff on duty witnessed the incident. Staff escorted [Resident #2] back to room. Nursing staff immediately notified DON and ADONof incident. DON, came to notify me of incident. [Resident 1] unable to retell events of what occurred. He was witnessed walkingdown hall and appears to be calm at this time. [Resident 2]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported no later than 24 hours after the allegation is made to the administrator of the facility and to HHSC, if the events that cause the allegation do not involve abuse, and do not result in serious bodily injury for 2 (Resident #1 and Resident #2) of five residents reviewed for reporting abuse and neglect. The facility failed to report an allegation of abuse made by Resident #2 on 10/10/25 that did not result in bodily injury within 24 hours to the state agency. This failure could place residents at risk of abuse, trauma, and/or psychosocial harm. Findings included:Review of Resident #1's comprehensive MDS assessment, dated 09/10/25, reflected a [AGE] year-old male who was on 09/10/2021. His diagnoses included: progressive neurological conditions (gradual decline in neurological function), diabetes mellitus (chronic condition that affects how your body processes blood sugar), Alzheimer's disease (memory impairment), seizure disorder (abnormal electrical activity in the brain), anxiety (feelings of worry, fear, or unease), depression (persistent feeling of sadness), psychotic disorder (severe mental health conditions). His BIMS score was a 3, indicating severe cognitive impairment. Review of Resident #1's care plan, dated 9/28/25, revealed he was care planned for having a behavior problem of wandering with interventions of, Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.Review of a nursing incident/accident investigation worksheet, dated 10/10/25 by agency LVN A, revealed that on 10/10/25 at 2:15 p.m. physical aggression was initiated by Resident #1 and there was resident to resident contact. Under the investigation summary section, it was indicated the Resident #2 did not say what happened, the staff did not know what caused the incident, and there were no witnesses. The statement also reflected, When staff arrived at D/R this resident [Resident #1] had the other resident [Resident #2] on the floor-holding him down. The other resident [Resident #2] was noted lying on the floor with his shoulders up-trying to release himself from the resident.Review of Resident #1's progress note, dated 10/10/25 documented by agency LVN A, revealed, Nurse and medication aide heard resident calling out for help. When we arrived at D/R this resident had the other resident on the floor holding him down. The other resident was noted lying on the floor with his shoulders up-trying to release himself from the resident. No apparent injuries noted to residents. The NP was informed via phone with orders for U/A. Psychiatric NP here with new orders: Depakote and Hydroxyzine-See Orders.Review of Resident #1's progress note, dated 10/23/25, revealed he was admitted to a behavioral health inpatient facility.Review of Resident #2's quarterly MDS assessment, dated 09/01/25, reflected a [AGE] year-old male who admitted on [DATE]. His diagnoses included: heart failure, renal failure (medical condition in which the kidneys can no longer filter waste products from the blood), diabetes mellitus (chronic condition that affects how your body processes blood sugar), non-Alzheimer's dementia, anxiety (feelings of worry, fear, or unease), depression (persistent feeling of sadness), insomnia (inability to sleep), and malnutrition. His BIMS score was a 4, indicating severe cognitive impairment. Review of Resident #2's care plan, dated 9/12/25, revealed he was care planned for the potential to be physically aggressive when he pushed another resident on 1/25/25. His interventions included monitoring for agitation, redirection, give the resident choices, and to intervene before agitation escalates. Review of the facility's incident/accident reports from the last 3 months revealed that an incident occurred on 10/10/25 where physical aggression was received by Resident #2, and physical aggression was initiated by Resident #1.Review of a typed document on a piece of paper provided to the surveyor on 11/20/2025 at 1:05 p.m. by the DON and VPHR revealed: [Resident #2] and [Resident #1]Completed by [previous ADM], 10.10.25Staff heard a cry for help and went to dining room. Found [Resident #2] on the floor with [Resident #1] holding his shoulders. No staff on duty witnessed the incident. Staff escorted [Resident #2] back to room. Nursing staff immediately notified DON and ADONof incident. DON, came to notify me of incident. [Resident 1] unable to retell events of what occurred. He was witnessed walkingdown hall and appears to be calm at this time. [Resident 2] stated I don't know why he just walked up and hit me. Psych NP notified 10.10.25 of incident, came to facility, spoke with [Resident 1] and wrote new orders. Staff will continue to monitor for any adverse affects.An interview was attempted with the previous ADM on 11/20/2025 at 10:55 a.m. but the surveyor did not receive a return call after leaving a voicemail. In an interview on 11/20/2025 at 11:10 a.m. with the DON she stated it was not Resident #1's normal behavior to act in the way he did with Resident #2. She stated that she did not consider the incident to be abuse.