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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for 1 resident of 20 residents (Res#1) reviewed for quality of care. The facility failed to answer Res#1's call light after Res#1 pressed the call light button for 34 minutes. This failure could place residents at risk of not trusting the facility, physical harm, and mental anguish.Findings included: Record review of Res#1's admission's record dated 06/30/26 indicated she was a [AGE] year-old female admitted to the facility 09/29/25. Her diagnoses included other specified diabetes mellitus (group of diseases that affect how the body uses blood sugar) with diabetic neuropathy (common complication of diabetes, characterized by nerve damage that can lead to pain, numbness, and other disfunctions in the body) chronic obstructive pulmonary disease (a progressive lung disease that restricted air flow), unspecified, metabolic encephalopathy (brain dysfunction caused by chemical imbalances in the body rather than a structural injury), paroxysmal atrial fibrillation (an intermittent, irregular heart rhythm where the upper chambers of the heart (atria) beat chaotically), and acute kidney failure, and memory deficit following unspecified cerebrovascular disease (umbrella term for conditions that impact the blood vessels in your brain). Record review on 06/30/26 of Res#1's MDS assessment revealed her BIMS score was 13(normal cognitive function with little to no impairment. During an interview on 06/30/26 at 11:49 AM with Res#1, she said that she pressed her call light button the night before and no one came to her room. She said she called her FM and left a message for them to call the front desk to see if someone could take her to the restroom. She said there had been times when she pressed her call light and staff came about an hour later. Observation on 06/30/26 at 11:51 AM revealed that Res#1 pressed her call light button at 11:51 AM and a staff member did not come to her room until 12:25 PM. Observation also revealed that there was a light above her door that came on when she pressed the call light button. Observation on 06/30/26 at 12:15 PM of the nurse's station revealed there were two people sitting down behind the counter (positions unknown) at the nurse's station. Observation on 06/30/26 at 12:25PM revealed the REC came into the resident's room and asked her if she needed anything. The REC turned the call light button off by pushing the put on the wall connected to the cord of the call light. Observation revealed that the light above the door was off after REC pressed the button on the wall. During an interview on 06/30/26 at 12:25 PM with REC, she said that any staff member could answer a call light request. She stated that Res#1's FM called right before she came in the room on 06/30/26 and asked her to check Res#1's call light button because Res#1 called FM last night and left a message for FM to call the facility and ask if someone was available to take Res#1 to the bathroom. During an interview with the ADM 06/30/26? at 1:11 PM, she advised that the facility did not have a printed call light policy. She said she expected staff to answer call lights as soon as possible. She said she preferred staff to answer call lights within 15 minutes from the time a resident pushed it. She stated that there was a call light system on the wall directly behind the nurse's station. She stated that there was a red light that would come on by each room number when a resident pushed their call light button. She stated that the lights would make a beeping sound ADM said that delayed responses to call lights could lead to noncompliance with (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	federal regulations and increased complaints from residents. Observation on 06/30/26 at 1:17PM of the call light system revealed it was located in the middle of the wall behind the nurse's station. Observation revealed there were blinking red lights on the wall next to the room numbers which indicated a resident pressed their call light button. Observation revealed the lights made a beeping sound. During an interview on 06/30/26 at 1:19PM with CN, she said there was not a printed call light policy. She stated that any staff member could answer a call light. She stated that staff should answer call lights as soon as possible. She stated that there was not a specific time limit because it could vary depending on what was going on in the facility. CN said it should not take staff longer than 30 minutes to answer a call light. She stated not answering a call light within a certain time limit could cause residents to be at risk of being in danger or in pain. During an interview on 06/30/26 at 4:22 PM with DON, she said there was not a call light policy printed. DON said that there was not a specific time limit for answering call lights because it depended on what staff were doing at the time. She said any staff member could answer a call light. DON said it should not take longer than 30 minutes to answer a call light DON advised she did not know why it took over 30 minutes for the call light to be answered. She stated not answering a call light within a certain time limit could cause a resident to experience emotional distress, feel anxious, or feel ignored and lose trust in staff.