

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER Wesley Woods Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Woodgate Drive 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 5 residents (Resident #2) observed for resident rights.</p> <p>The facility failed to ensure Resident #2 was treated with respect and dignity when providing personal care for this resident.</p> <p>This failure could place residents at risk of lowered self-esteem, depression, and frustration.</p> <p>Findings included:</p> <p>Record Review of Resident #2's admission record revealed Resident #2 is an [AGE] year-old woman. Resident #2 was admitted to the facility on [DATE] with diagnosis of Alzheimer's Disease (a progressive brain disorder that slowly destroys memory and thinking skills, eventually impacting the ability to conduct even the simplest tasks), Depression and Anxiety Disorder.</p> <p>Record Review of Resident #2's care plan revealed.</p> <p>1.</p> <p>Focus Area dated 07/10/2023, indicating Resident #2 has a history of resisting/refusing care and can become physically and verbally aggressive during care.</p> <p>2.</p> <p>Focus Area dated 07/23/2023, indicating Resident #2 has difficulty communicating needs due to history of Alzheimer's diagnosis.</p> <p>3.</p> <p>Focus Area dated 07/29/2023, indicating Resident #2 has anxiety.</p> <p>Observation on 06/24/2025 at 1:15PM of Resident #2 sitting in her wheelchair at the front of the unit. Resident #2 appeared calm and relaxed during this observation. Resident #2 began crying when this HHSC Investigator approached her. Resident #2 was unable to voice what was wrong with her.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #2 MDS record dated 03/31/2025 revealed that Resident #2 has a BIMS of 00, which indicate severe cognitive impairment.</p> <p>Record Review of facility's Investigation Report #regarding Resident #2 revealed the following:</p> <ol style="list-style-type: none"> Staff member provided a written summary stating they had been frustrated with Resident #2 while providing care due to the unusually demanding workload, resulting in frustration, and stated unprofessional works and statements to Resident #2. Resident #2's informed the facility that the staff member told Resident #2 don't touch me, there is no one here to help you. In-services on Abuse, Neglect, Resident Rights and Electronic Monitoring was provided to the facility staff. <p>Record Review of Nursing Note dated 06/08/2025 by LVN revealed Resident #2's family member called and stated the night aide was rough with Resident #two. Skin assessment was completed with no visuals of marks or bruises.</p> <p>Interview on 06/24/2025 at 3:26PM with DON revealed that the ADM provides training on Resident Rights to staff members upon hire and anytime there is suspected abuse or neglect. The DON stated Resident Rights training includes the differences between abuse and neglect, steps to take during a suspected abuse claim as well as to whom to report. The DON stated the expectation on how residents are treated is with dignity and respect. The DON stated the steps the facility takes during an abuse investigation is to suspend the suspected employee, complete interviews, and review footage if available. The DON stated during the investigation with the suspected employee, they confirmed that they did not speak to Resident #2 with respect, and dignity while providing personal care. The DON stated the suspected employee was terminated upon completion of the investigation. The DON stated the result of the investigation was founded.</p> <p>Interview on 06/24/2025 at 4:08PM with ADM revealed that ADM provides Resident Rights trainings to staff upon hire and quarterly. The ADM stated this training includes screening of abuse, different types of abuse, and to whom to report suspected abuse or neglect. The ADM stated the expectation on how residents are treated is to treat them fairly and ensure they are free from abuse or neglect. The ADM stated the typical result of abuse/neglect investigation is to terminate employment with the employee. The ADM stated the result of Resident #2's investigation was that the staff member was witnessed on camera mistreating Resident #1 therefore resulting in termination of employment.</p> <p>Record Review of facility undated policy titled Resident Rights revealed:</p> <ol style="list-style-type: none"> (continued on next page) 		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The purpose of this policy is to ensure that resident rights are respected and protected, and to inform residents of their rights and provide an environment in which they can be exercised.</p> <p>2.</p> <p>The resident has the right to:</p> <p>a.</p> <p>A dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.</p> <p>b.</p> <p>Exercise their rights as a resident of the facility and as</p> <p>c.</p> <p>Be treated with respect and dignity.</p> <p>d.</p> <p>To be free from abuse, neglect, and misappropriation of resident's property. Record Review of Resident #2 MDS record dated 03/31/2025 revealed that Resident #2 has a BIMS of 00, which indicate severe cognitive impairment.</p> <p>Record Review of facility's Investigation Report #regarding Resident #2 revealed the following:</p> <p>1.</p> <p>Staff member provided a written summary stating they had been frustrated with Resident #2 while providing care due to the unusually demanding workload, resulting in frustration and stated unprofessional works and statements to Resident #2.</p> <p>2.</p> <p>Resident #2's daughter informed the facility that the staff member told Resident #2 don't touch me, there is no one here to help you.</p> <p>3.</p> <p>In-services on Abuse, Neglect, Resident Rights and Electronic Monitoring was provided to the facility staff.</p> <p>Record Review of Nursing Note dated 06/08/2025 by LVN revealed Resident #2's family member called and stated the night aide was rough with Resident #2her mother. Skin assessment was completed with no visuals of marks or bruises.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/24/2025 at 3:26PM with DON revealed that the ADM provides training on Resident Rights to staff members upon hire and anytime there is suspected abuse or neglect. The DON stated Resident Rights training includes the differences between abuse and neglect, steps to take during a suspected abuse claim as well as who to report to. The DON stated the expectation on how residents are treated is with dignity and respect. The DON stated the steps the facility takes during an abuse investigation is to suspend the suspected employee, complete interviews, and review footage if available. The DON stated during the investigation with the suspected employee, they confirmed that they did not speak to Resident #2 with respect, and dignity while providing personal care. The DON stated the suspected employee was terminated upon completion of the investigation. The DON stated the result of the investigation was founded.</p> <p>Interview on 06/24/2025 at 4:08PM with ADM revealed that ADM provides Resident Rights trainings to staff upon hire and quarterly. The ADM stated this training includes screening of abuse, different types of abuse, and who to report suspected abuse or neglect to. The ADM stated the expectation on how residents are treated is to treat them fairly and ensure they are free from abuse or neglect. The ADM stated the typical result of abuse/neglect investigation is to terminate employment with the employee. The ADM stated the result of Resident #2's investigation was that the staff member was witnessed on camera mistreating Resident #1 therefore resulting in termination of employment.</p> <p>Record Review of facility undated policy titled Resident Rights revealed:</p> <ol style="list-style-type: none"> 1. <p>The purpose of this policy is to ensure that resident rights are respected and protected, and to inform residents of their rights and provide an environment in which they can be exercised.</p> 2. <p>The resident has the right to:</p> <ol style="list-style-type: none"> a. <p>A dignified existence, self-determination, and communication with and access to persons and services inside and outside eth the facility.</p> b. <p>Exercise their rights as a resident of the facility and as</p> c. <p>Be treated with respect and dignity.</p> d. <p>To be free from abuse, neglect and misappropriation of resident's property.</p> 		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to provide each resident at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care for three (Resident #1, Resident #3, and Resident #5) of 5 reviewed for timely meals.</p> <p>The facility failed to provide breakfast, lunch, and dinner according to the designated meal service schedules on multiple occasions.</p> <p>This deficient practice could place residents at risk of low blood sugar levels, increased stress levels, slowed metabolism rates, weakened immune systems, malnutrition, weakened hearts, and organ failures.</p> <p>Findings include:</p> <p>Interview on 06/24/2025 at 10:47AM with OMB revealed that lunch had been served late to the residents as late as 2PM while OMB was at the facility. OMB stated late meals had been served to residents more than once in the month of May and June.</p> <p>Observation on 06/24/2025 at 12:11PM revealed that lunch trays had been served in the dining room.</p> <p>Record review of Resident #1's admission record revealed Resident #1 is a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of Hereditary and Idiopathic Neuropathy (inherited conditions that affect the peripheral nervous system, leading to progressive nerve damage) and Essential Hypertension (most common type of high blood pressure).</p> <p>Record Review of Resident #1 MDS record dated 05/14/2025 revealed that Resident #1 has a BIMs of 15 which indicates no cognitive impairment.</p> <p>Interview on 06/24/2025 at 1:30PM with Resident #1 revealed that mealtimes are often served late. Resident #1 stated that the meals are served later than designated mealtimes approximately 3 times per week. Resident #1 described late as 9:00AM for breakfast when scheduled breakfast is from 7:30-8:30AM, and 2:00 PM for lunch when scheduled lunch is from 11:30AM-12:30PM. Resident #1 stated being served meals late makes her feel hungry and displeased. Resident #1 believed late meals are a result of disorganization in the kitchen with staff.</p> <p>Record review of Resident #3's admission record revealed Resident #3 is a 89- year-old female who admitted to the facility on [DATE] with diagnosis of Hypertensive Chronic Kidney Disease with Stage 1 through Stag 4 Chronic Kidney Disease (high blood pressure and kidney damage occur together, progressing through stages 1 to 4) and Mixed Hyperlipidemia (genetic condition where a person has elevated levels of both cholesterol and triglycerides in their blood).</p> <p>Record Review of Resident #3 MDS record dated 03/27/2025 revealed that Resident #3 has a BIMs of 15 which indicates no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/24/2025 at 1:40PM with Resident #3 revealed that they are used to meals coming late due to it happening so often. Resident #3 stated that lunch has often been served at 2:00PM when it is scheduled for 11:30AM-12:00PM. Resident #3 stated that dinner had once been served at 8:00PM due to lunch being served late. Resident #3 stated this made them feel like the staff/facility had forgotten about them. Resident #3 stated this made them feel disgusting. Resident #3 believed late meals are a result of disorganization.</p> <p>Interview on 06/24/2025 at 2:00PM with Resident #5 revealed that mealtimes are disorganized. Resident #5 stated that meals are often late. Resident #5 could not explain why meals could be late .</p> <p>Interview on 06/24/2025 at 2:25PM with DM revealed that DM had been employed at the facility for 2 months. The DM stated mealtimes are 7:00AM, 11:10AM, and 4:45PM. The DM stated there have been times where meals are late. The DM stated residents were served lunch at 2:00PM approximately 4 weeks prior, due to the head cook walked out of the kitchen and did not return. The DM stated this could negatively impact a resident's capability to receive their medications. DM stated snacks are offered 3x a day and is delivered to the units.</p> <p>Interview on 06/24/2025 at 2:45PM with LVN A revealed that LVN A had been employed at the facility for 14 years. LVN A stated mealtimes are 5:00PM-6:00PM for dinner. LVN A stated that they had entered the evening shift to work at 1:30PM, and hall carts had still been on the unit. LVN A stated this was because lunch was served late, resulting in dinner being served after 6:00PM. LVN A stated something like this had happened approximately 3 times. LVN A stated this could negatively impact a resident who is diabetic and cause residents to be hungry.</p> <p>Interview on 06/24/2025 at 03:36PM with DON revealed that DON had been employed at the facility for almost 1 year. The DON stated that mealtimes are to be served at 8:00AM, 12:00PM and 5:00PM. The DON stated the expectation is timeliness for meal preparation and times. The DON stated this could negatively impact a resident by causing low blood sugar for diabetics, potential for missing medications that are required to be taken with meals and could cause GI issues . DON reported they provide snacks to residents.</p> <p>Interview on 06/24/2025 at 4:08PM with ADM revealed that ADM had been employed at the facility for almost 2 years. The ADM stated that the expectation as far as mealtimes, should be served on time. The ADM stated if meals are going to be late, they offer snacks to residents. The ADM stated this could negatively impact residents by being hungry and potentially weight loss. The ADM stated changes that have been made to avoid late mealtimes have been to hire new kitchen staff. The ADM stated the day that meals were served extremely late were due to the head chef quitting and walking out without notice. The ADM stated the facility did not know the staff member had left, resulting in late meals. ADM stated she had helped in the kitchen that day.</p> <p>Record review of document titles Resident Meal Service and Snacks provided by the facility revealed the following:</p> <ol style="list-style-type: none"> 1. <p>Resident meals will be served at regular hours with a maximum of fourteen hours between the evening meal and breakfast the following day.</p>		