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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676394 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Woodlands Place Rehabilitation Suites | | STREET ADDRESS, CITY, STATE, ZIP CODE 5600 Woodlands Trail Denison, TX 75020 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights. (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's responsible party had the right to exercise the resident's rights for one (Resident #2) of 6 residents reviewed for resident rights. The facility failed to ensure Resident #2's representative was involved in the decision making before inserting a catheter. This failure could place residents at risk of not having their preferred responsible party represent them in care decisions. Findings Included: Record review of Resident #2's face sheet revealed Resident #2 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2's face sheet identified his representatives were family members. Diagnosis included: Acute Prostatitis (painful bacterial infection and inflammation of the prostate gland causing pelvic pain, urgent, frequent or painful urination), Lack of Coordination, Cognitive Communication Deficit, Benign Prostatic Hyperplasia (pain and discomfort while urinating and inability to empty the bladder completely), Muscle Weakness and Mild Cognitive Impairment. Resident #2's face sheet revealed family members were listed as emergency contacts but they were not listed as POA. Record Review of Resident #2's admission Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS score of 08 which meant he had moderate cognitive impairment. The MDS revealed Resident #2 had difficulty communicating when he tried to make himself understood. Resident #2 missed some part or intent of message regarding his ability to understand others. Resident #2's MDS revealed it was very important to have family involved in discussions about his care. Record Review of Resident #2's Care Plan dated 11/11/25, revealed he had the need to urinate frequently and had decreased cognition. The resident's care plan revealed he had mild cognitive impairment. He yelled out for momma and please help me frequently which required frequent monitoring and redirection. The facility's approach was to determine if the resident was considered to have or not to have capacity to make medical decisions as evidenced by physician's order, psychological assessment, capacity declaration, or guardianship paperwork. The approach also included to encourage Resident #2's decision making when able with simple task, such as choice in clothing, snacks, and activities. Record Review of Resident #2's progress notes on 12/21/25 at 11:00 a.m. by RN-A revealed he was having difficulty in voiding and hollering that he needed to go pee despite going to the bathroom and not voiding. RN-A spoke with doctor and received an order to insert a catheter. Resident #2 continued stating he had to go pee even after catheter insertion. Interview on 12/23/25 at 11:06 a.m. with the DON revealed RN-A stated the nurse aide said Resident #2 had been saying he needed to void several times but was not putting out anything. RN-A got an order from the doctor for an in and out catheter. RN-A sent a text message to LVN-B letting her know about the order. DON stated Resident #2 told LVN-B no to having the catheter put in. RN-A went and explained the procedure to Resident #2, and he allowed her to proceed. DON stated Resident #2 had an enlarged prostate which would have caused bleeding. Interview on 12/23/25 at 11:16 a.m. with the Admin revealed Resident #2 told LVN-B no to the catheter. RN-A explained the process to Resident #2, and he allowed her to insert the catheter. RN-A said Resident #2 said it was hurting, but she explained it would hurt due to his enlarged prostate. Admin stated they normally would have called the family before placing a catheter. He stated a family member was in the other family member's room on the next hall. He stated the family member was POA. Admin stated both RN-A and LVN-B were written up for not contacting the family. Interview on 12/23/25 at 11:58 a.m. with Resident #2 stated he had no problems with any staff. He shook his head yes when asked if he was going home today and then he fell asleep. Interview on 12/23/25 at 12:03 p.m. with the RP revealed Resident #2 had felt like he had to use the restroom the entire time he had been at the facility due to his enlarged prostate. She did not understand why the facility did not call them to let them know before they placed the catheter. RP stated she and another family member had POA. She stated Resident #2 had dementia and did not remember a lot of things. Interview on 12/23/25 at 12:15 p.m. with the FM revealed the facility did not call any of the family. FM stated RP and another family member had power of attorney over Resident #2. Attempted interview with Physician on 12/23/25 at 3:25 p.m. a voice message was left on his office phone requesting a return call. Attempted interview with Physician on 12/23/25 at 3:37 p.m. to his cell phone number, a voice and text message were sent requesting a return call. Interview on 12/23/25 at 3:41 p.m. with RN-A, she stated she was the on-duty nurse on the weekend. She stated Resident #2 always yelled he had to go to the bathroom. She stated he had been taken to the bathroom [ROOM NUMBER] times in 30 minutes. She had called the Doctor and received orders for Resident #2 for an in and out catheter. She said</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p> |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents with indwelling urinary catheters receives appropriate treatment and services to prevent urinary tract infections to the extent possible for one (Resident #4) of three residents reviewed for Urinary Catheter or Urinary Tract Infection. -The facility failed to ensure that Resident #4 received care and services to avoid catheter-associated urinary tract infections to the extent possible as evidenced by not demonstrating sterile technique during indwelling urinary catheterization of Resident #4. This failure could place all residents requiring indwelling urinary catheters and catheter care at risk for catheter associated urinary tract infections or complications that could lead to serious harm. Record review of Resident #4's face sheet dated 12.23.2025 at 12:30 p.m. indicated he was a [AGE] year-old male admitted to this facility on 12.08.2025 with a diagnosis of obstructive and reflux uropathy (blockage of the passing of urine from the bladder), hyperlipidemia (high cholesterol level), muscle weakness, type two diabetes with hyperglycemia (high level of sugar in the blood), gastroesophageal reflux disease (relating to stomach acid), a fall, and encounter for orthopedic (related to bone or muscle) aftercare. Interview on 12.23.2025 at 2:58 p.m. with Resident #4 indicated an alert and oriented elderly male who stated he was admitted for physical therapy after a fall that required right knee surgery. He said he must have a catheter to help him urinate. He said the nurses removed his catheter earlier that day. He said he was uncomfortable and wanted to take a nap. He said, I wish they would hurry up and put the catheter back in I need to pee. [sic] Interview on 12.23.2025 at 3:45 p.m. with LVN E indicated she had worked at this facility for five years. She stated verbal orders from the NP had been received on 12.23.2025 to re-insert an indwelling urinary catheter for Resident #4. Observation for 12.23.2025 at 3:48 p.m., LVN E gathered supplies to include a sterile kit for the indwelling urinary catheter insertion for Resident #4. She explained the procedure to the resident and cleaned the surface of the bedside table to place supplies for the procedure. She washed her hands, put on PPE, and proceeded with the procedure. After LVN E opened the sterile indwelling urinary catheter kit, she stopped and looked down at the contents of the box. She stated, I can't remember how to proceed. [sic]. After approximately two minutes, LVN E turned to the surveyor and asked how to continue with the procedure. The surveyor asked how the facility policy and procedure guided the process. LVN E continued to stare at the contents of the indwelling urinary catheter box. LVN E was observed to pick up a drape used to protect skin, linens, and resident clothing against urine. She stated, I don't need this [sic] and was observed to lay the drape aside. LVN E took out two individually wrapped pairs of sterile gloves and put on one pair without washing her hands after removing dirty gloves. She was observed to not connect the urine drainage bag to the sterile indwelling urinary catheter tube prior to inserting the sterile tube into the urinary meatus (the opening leading to the interior of the urinary system). The drainage bag was not noted to be pre-connected. Interview with LVN E on 12.23.2025 at 4:16 p.m. indicated she realized she failed to maintain sterile technique by not washing her hands after removing dirty gloves to put on sterile gloves. She realized she failed to connect the urinary drainage bag to the end of the sterile catheter tube prior to inserting tube into the urinary meatus. LVN E stated her future expectation would be to review and follow policy and procedures to prevent the risk of introducing bacteria into a resident's bladder and causing a CAUTI. Interview with the DON on 12.23.2025 at 4:30 p.m. indicated the facility did not use written policies and procedures for inserting indwelling urinary catheters to male or female residents. The DON stated a Lippincott Manual; 9th Edition printed in 2023 was used for standards of nursing care. Skill check off for all nursing staff is done annually. Review of the Lippincott Manual instructions for Indwelling Urinary Catheter Insertion indicated these areas were not followed. To use sterile techniques when inserting, manipulating, and maintaining the indwelling urinary catheter. Maintain a sterile, continuously closed drainage system. Place a fluid-impermeable pad on the bed between the resident's legs and under the hips. Using sterile no-touch technique to open the insertion kit wrap. Wash hands prior to donning (putting on) sterile gloves. If the urine drainage bag is not preconnected, attach it to the other end of the catheter using sterile gloves.</p> | | |