STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675360	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Springs Nursing Center	1010 Dallas St Waco, TX 76704

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (Resident #1) reviewed for rights. The facility failed to ensure Resident #1's doctors' orders were followed by not providing his antibiotic medications on 12/23/2025. This failure could place residents at risk for decreased quality of life, decreased self-esteem and diminished dignity. Findings included: Record review of Resident #1's face sheet dated 12/30/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses paraplegia, unspecified (paralysis affecting the lower half of the body (legs and sometimes trunk), but without specific details on the exact cause, severity (complete vs. incomplete), or level of spinal cord involvement provided in the medical record), stage four pressure ulcer or right buttock (a severe, deep open wound involving full-thickness tissue loss, where skin, fat, muscle, tendon, or even bone is exposed), other acute osteomyelitis, left ankle and foot (a sudden, serious bacterial or fungal infection in the bone, causing pain, swelling, redness, warmth, and possibly fever, often resulting from an injury, wound (especially with diabetes/poor circulation), or surgery, requiring urgent treatment with antibiotics and sometimes surgery to prevent permanent bone damage or amputation), scoliosis (a medical condition where the spine develops an abnormal sideways curve, often resembling a C or S shape, instead of being straight). Record review of Resident #1's most recent MDS, dated [DATE], reflected a BIMS score of 15, indicating cognition was intact. Record review of Resident #1's care plan, dated 12/29/2025, reflected Resident #1 had an infection and was on antibiotic therapy r/t sepsis (the body's extreme reaction to am untreated infection). Goal: Resident #1 would be free from complications related to infection through the review date 1/01/2026. Intervention/tasks included administering antibiotic as per MD orders, encourage po fluids if not contraindicated, monitored reactions and notify MD. Record review of Resident #1's care plan 12/22/2025 did not reflect he was receiving antibiotic therapy. Observation and record review of Resident #1's discharge orders, dated 12/23/2025, from a hospital stay revealed Resident #1 was discharged with two (2) antibiotics Linezolid 600 mg BID and Cipro 500 mg BID to be given 12/22/2025 through 12/27/2025. During an interview and observation on 12/30/2025 at 2:15 p.m., Resident #1 was asked if he was given his medication and he responded no. He stated he had antibiotics ordered when he was discharged from the hospital and the facility did not know until he asked about the medication. He stated he expected the nurses to have his medication. Resident appeared to be clean sitting in the wheelchair. During an interview on 12/30/2025 at 6:05 p.m., LVN A revealed when a resident was discharged from the hospital it was the responsibility of the charge nurse on duty to put the orders in the electronic system. LVN A stated Resident #1 was readmitted back into the facility after her shift. She stated she caught the Cipro 500 mg BID medication Resident #1 was prescribed. LVN A stated Resident #1 asked about his discharge paperwork regarding his antibiotics the doctor prescribed for him, and she stated she was going to investigate it. The NP made rounds on the morning of 12/24. She notified the NP that Resident #1 did not receive his antibiotics and asked what to do next. LVN A stated he was supposed to be on the antibiotics for three days and he stated to extend it to five days, so she put the order in for five days. She stated the medication should have been in the e-kit (a small supply of medications kept in the home to quickly treat symptoms that may occur in a terminally ill patient). She thought Resident #1 received his medication on 12/25. Once she put it in the orders, he should have gotten the evening dose. The initial dose is given by the nurse and then the med tech can give medication. LVN A stated it was the residents' right to receive all their medications on time. During an interview on 12/30/2025 at 6:15 p.m., Charge Nurse A revealed it was everybody's responsibility to make sure orders were correctly put into the electronic system. Charge Nurse A stated the marketing person would bring the discharge paperwork to the nurses then the nurses will add the necessary documentation into the computer. The DON and ADON are supposed to go behind the nurse to make sure it is done. Sometimes the ADON or the DON would put the orders in. Charge Nurse A stated he does not know why the medications were missed. He stated Resident #1 returned to the facility about 9:20 p.m. after being gone for 72 hours and readmitted as a new admit. He stated he gave Resident #1 the initial medication for one of the medications and he had to call the pharmacy for the Linezolid medication. He stated the paperwork reflected what happened during resident hospital stay and not the medication. He stated the next morning, the paperwork that came reflected the doctors' medication

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	675360	A. Building B. Wing	12/30/2025

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents were free of significant medications errors for one of three residents (Resident #1) reviewed for any significant medication errors, in that: The facility failed to ensure Resident #1 received his medications as prescribed by the physician. This failure affected residents by putting them at risk of exacerbation of their health conditions and deterioration of their health. Findings included: Record review of Resident #1's face sheet dated 12/30/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses paraplegia, unspecified (paralysis affecting the lower half of the body (legs and sometimes trunk), but without specific details on the exact cause, severity (complete vs. incomplete), or level of spinal cord involvement provided in the medical record), stage four pressure ulcer or right buttock (a severe, deep open wound involving full-thickness tissue loss, where skin, fat, muscle, tendon, or even bone is exposed), other acute osteomyelitis, left ankle and foot (a sudden, serious bacterial or fungal infection in the bone, causing pain, swelling, redness, warmth, and possibly fever, often resulting from an injury, wound (especially with diabetes/poor circulation), or surgery, requiring urgent treatment with antibiotics and sometimes surgery to prevent permanent bone damage or amputation), scoliosis (a medical condition where the spine develops an abnormal sideways curve, often resembling a C or S shape, instead of being straight). Record review of Resident #1's most recent MDS, dated [DATE], reflected a BIMS score of 15, indicating cognition was intact. Record review of Resident #1's care plan, dated 12/29/2025, reflected Resident #1 had an infection and was on antibiotic therapy r/t sepsis (the body's extreme reaction to am untreated infection). Goal: Resident #1 would be free from complications related to infection through the review date 1/01/2026. Intervention/tasks included administering antibiotic as per MD orders, encourage po fluids if not contraindicated, monitored reactions and notify MD. Record review of Resident #1's care plan 12/22/2025 did not reflect he was receiving antibiotic therapy. Observation and record review of Resident #1's discharge orders, dated 12/23/2025, from a hospital stay revealed Resident #1 was discharged with two (2) antibiotics Linezolid 600 mg BID and Cipro 500 mg BID to be given 12/22/2025 through 12/27/2025. During an interview and observation on 12/30/2025 at 2:15 p.m., Resident #1 was asked if he was given his medication and he responded no. He stated he had antibiotics ordered when he was discharged from the hospital and the facility did not know until he asked about the medication. He stated he expected the nurses to have his medication. Resident appeared to be clean sitting in the wheelchair. During an interview on 12/30/2025 at 5:35 p.m., the PCP revealed she was more familiar with Resident #1 in the hospital. She described his medical condition and stated healing was difficult for Resident #1. The PCP stated because of osteomyelitis the CT scan was inconclusive, and the 3rd toe amputee was the source control. Resident #1 had multiple rounds of antibiotics and was battling with the infection. The PCP stated the antibiotic was to make sure the infection cleared. The amputation cleared him, but the 2 antibiotics were just to make sure everything was clear. The PCP stated the antibiotics were given to ensure the infection was cleared. She stated the blood cultures they took while in the hospital did not reveal any growth. The PCP stated he could have a flare up of another infection. During an interview on 12/30/2025 at 6:05 p.m., LVN A revealed when a resident was discharged from the hospital it was the responsibility of the charge nurse on duty to put the orders in the electronic system. LVN A stated Resident #1 was readmitted back into the facility after her shift. She stated she caught the Cipro 500 mg BID medication Resident #1 was prescribed. LVN A stated Resident #1 asked about his discharge paperwork regarding his antibiotics the doctor prescribed for him, and she stated she was going to investigate it. The NP made rounds on the morning of 12/24. She notified the NP that Resident #1 did not receive his antibiotics and asked what to do next. LVN A stated he was supposed to be on the antibiotics for three days and he stated to extend it to five days, so she put the order in for five days. She stated the medication should have been in the e-kit (a small supply of medications kept in the home to quickly treat symptoms that may occur in a terminally ill patient). She thought Resident #1 received his medication on 12/25. Once she put it in the orders, he should have gotten the evening dose. The initial dose is given by the nurse and then the med tech can give medication. LVN A stated the adverse reaction that could happen with Resident #1 the antibiotics is he could go septic shock. During an interview on 12/30/2025 at 6:15 p.m., Charge Nurse A revealed it was everybody's responsibility to make sure orders were correctly put into the electronic system. Charge Nurse A stated the marketing person would bring the discharge paperwork to the nurses then the nurses will add the necessary