STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015179	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health Care Facility	3301 Stadium Drive Phenix City, AL 36867

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and a facility policy title Cleaning Dishes/Dish Machine: the facility failed to ensure sanitary conditions were maintained in the dishwashing area to prevent cross contamination. Specifically, staff were observed working on both the soiled (dirty) side and the clean side of the dish room without changing gloves between tasks.This practice had the potential to affect 71 of 71 residents who received meals from the kitchen.Findings Include: A facility policy titled, Cleaning Dishes/Dish Machine dated 2023 revealed: . Procedure: Staff will follow these procedures for washing dishes: . 2. The person loading dirty dishes will not handle the clean dishes unless they change into a clean apron and wash their hands thoroughly before moving from dirty to clean dishes. On 02/10/2026 at 5:25 PM the surveyor observed Dietary Aide (DA) #17 on the dirty side of the dish room. DA #17 put approximately 20 glasses in a crate and pushed them into the dish machine. DA #17 then proceeded to the clean side of the dish room and pulled dishes out of the dish machine without changing his gloves. On 02/12/2026 at 10:38 AM DA #17 was asked what area of the dish room he worked in on 02/10/2026. DA #17 said both the dirty and clean side. DA #17 stated he was putting the dirty dishes in the machine and pulling them out of the machine after they were cleaned and putting the dishes up. DA #17 said he did not change gloves when moving from the dirty side of the dish room to the clean side of the dish room. DA #17 said he worked both the dirty and clean side when he was the only staff working is the dish room. DA #17 was asked what the potential harm to the residents was when staff use the same gloves on the dirty and clean side of the dish room. DA #17 stated cross contamination and it could make the residents sick. On 2/12/2026 at 11:10 AM District Manager (DM) #18 was asked what side of the dish room did DA #17 work on and he stated DA #17 worked on the dirty side. DM #18 was asked to describe what tasks were performed by DA #17 while in the dish room. DM #18 stated DA #17 came over on the dirty side of the dish room and pushed glasses through the dish machine. DM #18 was asked why staff should change their gloves when working on the dirty side of the dish room and then moving to the clean side of the dish room. DM #18 stated to prevent cross contamination. DM #18 said he did not observe DA #17 change his gloves when he moved from the dirty to the clean side. DM #18 was asked what the potential harm to residents was when staff worked on the dirty and clean side of the dish room without changing their gloves. DM #18 stated cross contamination. DM #18 was asked what the facility policy was when working in the dish room on the clean and dirty side. DM #18 stated if staff was working on the dirty side they should stay on the dirty side and if working on the clean side they should stay on the clean side.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and the facility's policy titled Housekeeping the facility failed to ensure a safe, clean, and comfortable environment for three of 21 residents reviewed.Specifically Resident Identifier (RI) #3's, RI #41's, and RI #51's rooms had scrapes and holes in the drywall and cracks in the ceiling. Additionally, RI #3's and RI #41's room had brown stains observed on the ceiling, and the window blinds in RI #41's room were not functioning properly. These conditions had the potential to negatively impact residents' comfort and overall homelike environment. Findings Include:An undated policy titled Housekeeping documented: . Housekeeping is one of the most important environmental services since it plays a major role in providing a healthy, comfortable environment. OBRA requires housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. This service makes a significant contribution to facility-wide sanitary practices and prevents the spread of disease causing organisms. An orderly interior means an uncluttered physical environment in which residents and staff can function safely. Orderliness involves not only housekeeping but also nursing and maintenance . Includes: . (3) no peeling paint, visible water leaks, and plumbing problems. Orderliness may be involved in making a room homelike .RI #3 was admitted to the facility on [DATE].RI #41 was admitted to the facility on [DATE].RI #51 was admitted to the facility on [DATE].On 02/10/2026 at 9:29 AM the surveyor observed that in RI #41's room there was uneven drywall over patches, holes present in the drywall, a brown substance on the ceiling, and a broken window blind. RI #41 stated he/she had informed maintenance about the broken blind approximately one year prior. RI #41 stated he/she was told it would be replaced once it was received by the facility. On 02/10/2026 at 11:31 AM the surveyor observed the ceiling above RI #51's bed needed paint and cracks were observed in the ceiling.On 02/12/2026 at 10:50 AM the surveyor noted that the wall behind the bed of RI #3 was black and marked with scratches.On 02/12/2026 at 11:00 AM the Maintenance Director (MTD) was asked about the concerns in the rooms of RI #3, RI #41, and RI #51. The MTD said the blinds in RI #41's room did not open, the ceiling was stained brown and there were holes in the dry wall. When asked about the brown stain he said it looked like food and housekeeping needed to address it. The MTD said it was not homelike. When asked about RI #51's room the MD said it was not homelike and he would not want to stay in the room. On 02/12/2026 at 11:52 AM the Housekeeping Supervisor (HS) was asked about the concerns in RI #3 and RI #41's room. The HS said she was not aware of the stained ceiling or the malfunctioning blind. The HS did not know what the brown substance on the ceiling was and said the ceiling should be clean and free of stains. The HS said the blinds should be working properly and it was not a homelike environment.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident's medical records, review of Facility Reported Incidents (FRIs) received by the State Agency, the facility's investigative files, the facility's policies titled ABUSE POLICY and Behavior Management Program Policy and Procedures the facility failed to protect the residents' right to be free from physical abuse perpetrated by other residents. Specifically:1. On 06/08/2024 the facility failed to protect Resident Identifier (RI) #39's right to be free from physical abuse perpetrated by RI #78. On 06/08/2024 Registered Nurse (RN) #9 witnessed RI #78 slap RI #39 on the head. RI #78 had a history of aggressive behaviors, which included verbal and physical aggression. The facility failed to provide adequate supervision and interventions for RI #78 to prevent other residents from being abused.This was cited as a result of the investigation of Facility Reported Incident (FRI) / report number 461495.2. On 10/13/2025 the facility failed to protect RI #38's right to be free from physical abuse perpetrated by RI #5. RN #11 witnessed RI #5 slap RI #38 on his/her chest as RI #5 was passing by RI #38. In the weeks before the incident, RI #5 had documented episodes of delusions and on 10/10/2025 RI #5 had documented episodes of agitation/ screaming at othersThis was cited as a result of the investigation of Facility Reported Incident (FRI) / report number 2648556.These deficient practices affected four of ten residents reviewed for abuse concerns during the survey. Findings Include: The facility's policy titled Abuse Policy dated of October 2022 and the facility's policy titled Abuse Policy dated May 2025 documented: . ABUSE PREVENTION POLICY It is the policy . to ensure that each resident is free from . physical . abuse . In an effort to eliminate or minimize the risk of a resident being subjected to. physical. abuse, . [the facility] has an ongoing abuse prevention program which includes the following practices and procedures: . Behavior Management programs will be implemented, when necessary, to prevent occurrences and staff will monitor residents for changes that may trigger abusive behavior. These management programs shall be monitored on a regular basis by our Social Services staff. Definitions . Physical Abuse - Physical abuse includes, but is not limited to, hitting, slapping, pinching, or kicking. 1) On 06/08/2024 at 12:47 PM the State Agency received a FRI alleging Physical Abuse. It was reported that RN #9 witnessed RI #78 slap RI #39 on the head. The facility's policy titled Behavior Management Program Policy and Procedure with a reviewed date of April 2019 documented: Policy It is the policy of this facility to utilize non-pharmacological behavioral intervention and pharmacological intervention when medically necessary to meet the needs of residents with targeted (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors that may cause harm or impairment in functional capacity. Purpose To make attempts to manage targeted behaviors exhibited by a resident in order to improve their quality of life. Procedure 1. Identify residents with abnormal behavior, i.e., physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, other behavioral symptoms not directed at others (such as hitting or scratching self or vocal symptoms like screaming, rejection of care that is necessary to achieve the resident's goals for health and well being or wandering. 2. When an abnormal behavior is identified, staff will begin an evaluation to attempt to determine the cause of the behavior . 3. Social Services staff/behavior management designee will initiate a Behavior Tracking log for seven days to determine the frequency of the behavior, to include the behavior(s) exhibited, the time of day, what the staff/resident was doing when the behavior was exhibited, the intervention used and the effectiveness of the intervention. The Behavior Tracking Log will contain the known targeted behavior(s) and suggested interventions based on the residents preferences and choices that may be effective in reducing or controlling each known targeted behavior . RI #39 was admitted to the facility on [DATE] with diagnoses to include Shaken infant syndrome. RI #39's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/19/2024 documented long- and short-term memory problems and daily decision making was severely impaired. RI #78 was admitted to the facility on [DATE] and discharged on 06/11/2024. RI #78 was admitted with diagnoses to include Generalized anxiety disorder. RI #78's quarterly MDS with an ARD of 03/22/2024 documented a RI #78 had Brief Interview of Mental Status (BIMS) score of 2 out of 15 which indicated severe cognitive impairment. The care plan for RI #78, initiated on 12/23/2022, identified a risk for delusions, obsessive symptoms, anxiety, agitation, disorientation regarding time and place, and a lack of awareness of recent events. The objectives of the care plan included prevention of behaviors that could impact others negatively. The interventions outlined included providing assistance in a calm manner, offering fluids and snacks, ensuring the availability of a baby doll, and in instances of tearfulness, providing a magazine, pictures, stuffed animals, an activity blanket, or other activities that offered comfort and reassurance. RI #78's 7 Day Observation Tracking Log Form for the month of May 2024 documented that RI #78 had behaviors of biting and cussing staff. During an interview conducted on 02/12/2026 at 3:21 PM with the Social Service Designee (SSD) she was asked about the behavior of RI #78 in May 2024. The SSD indicated that based on the seven-day observation tracking form, RI #78 exhibited behaviors such as biting and cursing at staff. The SSD noted that following each incident the resident would have been observed for a duration of seven (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days. When asked whether the seven-day tracking form included information on the level of supervision, she responded no, stating that it focused on behaviors and interventions instead. The SSD said that all residents were monitored every two hours, and she was uncertain about the specific level of supervision required for RI #78 in May and June of 2024. On 02/11/2026 at 10:47 AM RI #60 stated he/she had a vague recollection of the incident and said RI #78 used an open hand to hit RI #39 on the right side of the his/her. On 02/11/2026 at 11:15 AM, RN #9 recalled the incident that occurred in June 2024, involving RI #78 and RI #39. RN #9 reported that she witnessed RI #78 strike RI #39 on the back of the head with an open hand. RN #9 said the incident involving RI #78 and RI #39 was physical abuse. On 02/11/2026 at 4:22 PM, Former Licensed Practical Nurse (FLPN) #10 stated she remembered the incident involving RI #78 and RI #39 that occurred in June 2024. FLPN #10 said a resident hitting another resident was physical abuse and would likely cause a reasonable person to experience pain or fear. FLPN #10 said RI #78 exhibited signs of agitation at times. On 02/11/2026 at 2:19 PM during an interview the Administrator (ADM) he was asked about the incident involving RI #78 and RI #39 that occurred in June 2024. The ADM stated that the incident was reported to the state agency as a case of physical abuse and was substantiated, as it was witnessed by both a staff member and a resident. The ADM recalled that RI #78 had struck RI #39 with an open hand. When questioned about how a reasonable person might feel after being hit in the head he indicated it would depend on individual interpretation. The ADM was asked about the level of supervision RI #78 had at the time of the incident. He said RI #78 did not require any special supervision. 2.) On 10/13/2025 at 5:13 PM, the facility notified the State Agency of an allegation of physical abuse when Activity Assistant (AA) #12 and RN #11 witnessed RI #5 slap RI #38 on the chest while passing by each other in the hallway near the nurse's station. The facility's titled Behavior Management Program Policy and Procedures, policy dated 10/2025 documented: Policy It is the policy of this facility to utilize non-pharmacological behavioral intervention and pharmacological intervention when medically necessary to meet the needs of residents with targeted behaviors that may cause harm . Purpose To make attempts to manage targeted behaviors exhibited by a resident in order to improve their quality of life. Procedure. 2. Identify behaviors that may provoke a reaction by residents or others, which include, but are not limited to: *Verbally aggressive behavior, such as screaming, cursing, bossing . *Physically aggressive behavior, such as biting, spitting, threatening gestures . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. When abnormal behavior is identified, staff will begin a Behavior Tracking Evaluation observation to determine the cause of the behavior. 4. If the targeted behavior continues and interventions are found that reduce the behaviors or effect of the targeted behavior on the residents or others, the tracking will be discontinued . Behavior tracking will be re-initiated for behaviors identified with ineffective interventions . RI #38 was admitted to the facility on [DATE] and had diagnoses that included Dementia, severe with behavioral disturbances and Mood disorder due to known physiological condition with depressive features. RI #38's Quarterly MDS with an ARD of 08/19/2025 revealed intact cognition. RI #38's delirium care plan with a start date of 05/26/2025 indicated RI #38 had a history of being at risk for emotional distress. RI #38 would repeatedly yell out when he/she wanted or needed something. RI #38 would yell random things to anyone in his/her sight. RI #5 was admitted to the facility on [DATE] and had diagnoses to include Dementia, moderate with agitation. RI #5's MDS with an ARD of 09/03/2025 revealed RI #5 had severe cognitive deficits. RI #5 had a behavior care plan in place with a start date of 10/09/2025 that revealed RI #5 would exhibit physical behavioral symptoms directed at others such as hitting, kicking and pushing. RI #5 would become agitated or aggressive toward other, exhibit verbal behaviors directed at others, would wander around looking for his/her children and would become agitated or emotional when unable to find them. Interventions included keeping RI #5 out of arms reach from other. A review of a facility document titled Resident Progress Notes dated 09/30/2025 at 3:38 PM revealed RI #5 had an episode of emotional distress over a missing child and dog. That same day, RI #5 was placed on behavior tracking due to medication changes and increased emotional distress. The notes documented that RI #5's behavior tracking ended on 10/07/2025 and interventions were effective. A review of a facility document titled Medication Administration Record (MAR) indicated RI #5 had 5 episodes of Delusions on 10/08/2025. On 10/09/2025 the MAR indicated RI #5 had episodes of Delusions on all shifts. A review of a facility document titled Point of Care History indicated on 10/10/2025 RI #5 had episodes of agitation/ screaming at others. Interventions used by staff to provide redirection were documented as not effective. RI #5's MAR documented that on 10/11/2025 RI #5 had 1 episode of Delusions on the evening shift. The facility's investigative file included a signed handwritten witness statement from RN #11 dated 10/13/2025 at 5:45 PM. That statement documented that RN #11 was at the nurses' station and witnessed RI #5 get up to walk. RN #11 went to assist RI #5 to keep him/her from falling. At that same time, AA #12 was assisting RI #38 back to his/her room. When they passed by RI #5, RI #38 yelled at RI #5 you gotta get in your chair, which seemed to have triggered RI # 5, who reached over and hit RI #38 on his/her left chest wall with his/her hand. Staff immediately separated RI #5 and RI (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#38 and reported the incident to the Administrator. On 02/11/2026 at 11:13 AM an interview was conducted with RN #11 who verified the written statement of events that occurred on 10/13/2025. RN #11 said the incident would be considered physical abuse. On 02/11/2026 at 10:45 AM an interview was conducted with AA #12 regarding the incident on 10/13/2025. AA #12 said she was pushing RI #38 after the dinner meal back to his/ her room. When passing the nurses station they met RI #5 and RI #38 told RI #5 to sit down. AA #12 said RI #5 hit RI #38 in the chest with an open hand. AA #12 said that being hit in the chest would make someone feel upset. On 02/11/2026 at 3:42 PM an interview was conducted with the Administrator (ADM) regarding the incident on 10/13/2025. The ADM said he was notified of the allegation of physical abuse at 5:00 PM on 10/13/2025 by RN #11. The ADM said the incident was investigated by the facility and substantiated for physical abuse. ********** The facility implemented corrective actions before the survey team entered; thus, the deficient practice was cited at past non-compliance. ********** The facility took immediate action to correct the noncompliance including: On 06/08/2024 the facility immediately separated RI #78 and RI #39. Both residents were assessed and had no injury. The facility implemented enhanced supervision for RI #78. The facility reported the incident timely to the State Agency, Ombudsman, and resident representatives. The facility completed a thorough investigation of the incident. On 06/11/2024 the facility discharged RI #78 to an inpatient psychiatric facility. On 10/21/2024 the facility trained staff on prevention of resident on resident abuse and responding to abuse. On 11/11/2024 the facility educated all staff on starting Behavior Tracking, Proper Interventions, and location of the Behavior Tracking forms. On 12/31/2024 the facility educated staff on the Abuse and Dementia Care CMS Hand in Hand module 5) preventing and responding to abuse. 02/10/2025 Behavior management team met for QA and identified a concern regarding incomplete documentation on paper behavior tracking logs. Administration staff met with CNAs for feedback and determined that the electronic system is more assessable and allows for consistent and efficient documentation compared to the paper logs. New electronic system to track behaviors in working state. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/27/2025 Teams meeting training held with corporate nurses on new electronic behavior management process. Training completed. 03/10/2025 through 03/12/2025 Training on new behavior management process: Identify behavior concern, notify SS- who is to create a new care plan to target identified behaviors, coordinate with staff on new approaches, add to weekly nursing focus report, physician order placed by Unit Manager, Behavior binder at nurses' station for reference. Training competed on 03/12/2025. On 04/22/2025 during the quarterly QA meeting, the QA Committee reviewed facility Behavior Management PIP. The review included review of 02/2025 in-service on how to diffuse conflict between residents, communication with residents who may be upset or unable to communicate their needs. 05/08/2025 Training provided company wide on new behavior monitoring process – Part 1 completed. 1) Behavior Concern Report document 2) Behavior Focused Observation Document 3) Weekly Focus Resident Report document 4) Behavior Tracking Evaluation document 5) Medication Regime Review Document 6) Quarterly Psychotropic Evaluation document 7) Training/ QA Guide for BHV Managing Team document. 05/19/2025 Training provided to Nursing staff/ Administration on Revised Abuse Policy adding QAPI/ QAA completed. 05/20/2025 Training provided to Nursing/ All Staff on Dementia Training/MAPS – Behavioral changes in the skilled nursing facility setting, suggested activities based on GDS score 05/28/2025 Training provided to Nursing on Q & A Part 2 Behavior Tracking and Training consents for psychotropics. 05/28/2025 Training provided to Nursing/ Activity on GDS scores, what are they? How to find them on the care plan; Activity drawers locked in activity and family room. In July of 2025 Training to staff on Dementia Care: CMS Hand in Hand Module 1) Understanding the world of Dementia; the person and disease. 08/2025 Training to staff Dementia Care: CMS Hand in Hand Module 4) Being a person with Dementia. Making a Difference 08/15/2025 Training to CNA- reeducated on Behavior tracking; Check the Care Plan – Pull interventions from Care plan and type in comment section the intervention used and if successful On 10/13/2025 after the incident, RI #5 and RI #38 were immediately separated. A body audit was performed by an RN and no injury was identified. The incident was reported to administrative staff timely and an investigation was initiated. The facility immediately notified both residents' representatives and primary care provider and placed both residents on behavior monitoring program. Both residents were evaluated by a psychiatric clinician which recommended inpatient Geri-Psych evaluation for RI #5. On 10/13/2025 at 5:13 PM the facility reported the incident to the State Agency. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/2025 the facility notified the Ombudsman. On 10/14/2025 an emergency QA meeting was conducted. During chart review it was identified that RI #5 had been placed on Behavior Monitoring for medication changes, but not for the targeted behaviors he/she had been displaying. The facility had not initiated a Behavior Tracking Care Plan. On 10/14/2025 through 10/24/2025 the facility educated all staff on the facility's abuse policy and abuse prevention. On 10/20/2025 the facility completed their investigation and substantiated the incident of abuse involving RI #5 and RI #38. On 10/20/2025 the facility submitted their investigation to the State Agency. On 10/21/2025 through 10/31/2025 the facility completed an audit of all current residents' medical records for the past 30 days to determine if any resident had new behaviors, worsening behaviors, or behaviors with ineffective interventions and ensure residents with new behaviors, worsening behaviors, or behaviors with ineffective interventions had a behavior tracking order initiated for the target behaviors and an appropriate behavior tracking care plan initiated. The audit included a review of the behavior management care plan to ensure the care plan had been revised with effective interventions upon completion of behavior tracking. The review was documented in the Plan of Correction, progress notes, and EMAR. All concerns were addressed with appropriate corrective action. On 10/21/2025 the facility implemented a new system where a newly created Behavior Management QA Checklist was implemented to ensure all components of behavior tracking had been completed when new behaviors, worsening behaviors, or behaviors with ineffective interventions were identified. The QA Checklist included order for behavior tracking, the behavior tracking care plan, and revisions of behavior management care plan at the completion of tracking. The IDT team utilizes the checklist daily when reviewing residents' behaviors and review of daily documentation. 10/21/2025 Training on Behavior Monitoring with all staff completed. On 10/21/2025 through 10/31/2025 the facility educated the members of the IDT team on the updated behavior management system. On 10/21/2025 the facility began monitoring their corrective actions. The QA Nurse/designee monitored for compliance by reviewing documentation in resident's plan of care, progress notes, and EMAR for the past 30 days. Monitoring weekly for 4 weeks and then months for 5 months to determine any residents with documented new behaviors, worsening behaviors, or behaviors with ineffective interventions and verify a Behavior Management QA Checklist was completed for the resident as is included in the facility's binder. The review was documented on a monitoring tool and submitted to the Administrator responsible for implementing an appropriate plan of correction. 01/01/2025 -12/31/2025 Training to staff on Dementia Care: CMS Hand in Hand Module 2) Being a Person with Dementia: Listening and Speaking and Module 5) Preventing and Responding to Abuse ********** (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from 11/11/2024 to 12/31/2025 and past non-compliance was cited.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015179	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health Care Facility	3301 Stadium Drive Phenix City, AL 36867

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review and a facility policy titled, Care Planning Policy and Procedure, the facility failed to develop a comprehensive care plan to address Resident Identifier (RI) #53 use of PRN (as needed) oxygen. Record review indicated the resident received oxygen as needed however, there was no care plan in place to address the use of PRN oxygen, including indications, monitoring or staff interventions. This failure had the potential to result in inconsistent implementation of care and unmet respiratory needs.This deficient practice affect RI #53 one of one resident sampled for respiratory care.Findings Include: A policy titled Care Planning Policy and Procedure with a revised date of October 2022 documented: Policy: The care plan is a guide for all staff on a course of action that will attain or maintain a resident's highest practicable level of well-being. The care plan will be written in accordance with professional standards of practice and documentation. Communication about care plan changes should be ongoing among interdisciplinary team members.Procedure: 1. Facility staff will complete a care plan to meet the basic care needs of the resident within the first 48 hours of admission . This care plan will be updated as indicated to meet resident health/safety needs and used by the interdisciplinary team in formulation of the comprehensive care plan using the RAI process.RI #53 was admitted to the facility on [DATE] with diagnoses to include Hypertensive heart and Chronic kidney disease with heart failure.Physician Order's for RI #53 documented: . start date 11/03/2025 . O2(Oxygen) @ 2L(Liters)/Min(minute) Per Nasal Cannula PRN for SOB (Shortness of Breath), PAD Behind Ears, Check behind ears Q (every) shift when in use. As Needed .RI #53's Care Plan was reviewed by the surveyor and no care plan for as needed oxygen use was identified.On 02/13/2026 at 8:52 AM the surveyor observed RI #53 sitting in a chair in his/her room. RI #53's oxygen machine was observed but it was not in use. On 02/13/2026 at 8:29 AM the Minimum Data Set (MDS) Coordinator was asked about the care plan for RI #53's oxygen use. The MDS Coordinator said RI #53 had a current physician's order for oxygen dated 11/03/2025.The MDS Coordinator stated there was no current care plan in place for RI #53's oxygen use. She said she was responsible for developing the care plan for the use of oxygen and it was important so staff would know the resident needed oxygen and the purpose of its use.