

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Parkwood IN the Pines		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Hill Street Lufkin, TX 75904	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on observation, interview, and record review, the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 4 residents (Resident #39) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #39's Responsible Party was notified after she experienced pain in her right leg and had an X-ray ordered.</p> <p>This failure could place residents at risk of not being informed of illness, injury, and uncontrolled pain.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated 2/10/25 for Resident #39 indicated that she was an [AGE] year-old female admitted to the facility 12/16/21 with diagnoses including Alzheimer's disease and type 2 diabetes mellitus.</p> <p>Record review of a Comprehensive MDS assessment dated [DATE] for Resident #39 indicated that she had a BIMS score of 4, which indicated that she had severely impaired cognition. She required maximal assistance with all ADLs, and she was incontinent to bowel and bladder.</p> <p>Record review of a comprehensive care plan dated 10/31/24 for Resident #39 indicated that she had a potential for psychosocial well-being problem and had an intervention that read: .Increase communication between resident/family/caregivers about care and living environment: Explain all procedures and Treatments, Medications, Results of labs/tests, Condition, All changes, Rules, Options .</p> <p>Record review of a progress note dated 1/23/25 at 11:27 am for Resident #39 read .Resident complain of leg pain to the right leg. This nurse assessed resident and noticed swelling to the joint in the inner right ankle. Resident has pain when the foot is pushed toward her and when her leg if lifted. Resident doesn't have pain to the hip when the leg is moved. States only radiating type pain. Ankle is tender as well as knee. Hip is not tender to touch. No bruising noted to the right leg. Spoke with [name] NP for Dr. [name] regarding this information and order is given to obtain an x-ray of the right leg. Order placed with National Mobile x-ray . and was signed by LVN H.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a progress note dated 1/24/25 at 06:42 am for Resident #39 indicated that Xray results were reviewed and negative and was signed by LVN H.</p> <p>Record review of an electronic medical record from 1/23/25 to 2/11/25 for Resident #39 indicated no documentation of responsible party notification was found for Xray on 1/23/25.</p> <p>During an interview on 2/10/25 at 4:40 pm FM E said Resident #39 had begun complaining of pain the week before last and the facility ordered an Xray for her leg or knee, she could not remember which one, but the facility never called and told her. She said she had found out from the sitter. She said she wished the facility had called and told her themselves.</p> <p>During an interview on 2/12/25 at 2:20 pm DON said the nurse had told the sitter that day but should have called the RP as well. She said it could cause family to get upset if they are not kept informed, messages could be misunderstood or not relayed, and family would not know about their family members conditions. She said the nurse should have called the family member themselves.</p> <p>During an interview on 2/12/25 at 2:35 pm Administrator said the sitter had been in the room and had said she would call and tell the family member. Administrator said the nurse should have called themselves and informed the family. She said family should be notified by the facility and not a sitter.</p> <p>Record review of a facility policy titled Change in a Resident's Condition or Status dated 2001 and revised in May 2017 read .Our facility shall promptly notify the resident, his or her Attending Physician or Nurse Practitioner and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) . and .regardless of the resident's current mental or physical condition, a Nurse, Physician or Nurse Practitioner will inform the resident of any changes in his/her medical care or nursing treatments .</p>