STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455673	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood IN the Pines	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 6 residents (Residents #1) reviewed for medical records.The facility failed to ensure Resident #1's physician's orders were updated to include the resident was a DNR status and was uploaded in his medical record.This deficient practice could place residents at risk of improper care due to inaccurate medical records.The findings include:Record review of Resident #1's admission Record, dated [DATE], indicated a [AGE] year-old male who admitted to the facility on [DATE] and expired [DATE]. Resident #1 had diagnoses which included malignant neoplasm of colon (colon cancer), hypertensive heart disease (damaged heart muscle due to high blood pressure), anemia (not enough healthy red blood cells in the body) and infection of amputation stump, right lower extremity (infection in the right lower leg where it was cut off).Record review of Resident #1's active physician orders, dated [DATE], indicated he was a full code, dated [DATE], and there was not an end date.Record review of Resident #1's MDS Assessments indicated he had a death assessment dated [DATE].Record review of an interim care plan, dated [DATE], indicated he had terminal prognosis related to colon cancer and did not have a code status on the care plan.Record review of Resident #1's MDS Assessments indicated there was an entry assessment dated [DATE].Record review of an OOH DNR for Resident #1 was signed and dated [DATE] by Resident #1 and the MD.During an interview on [DATE] at 4:33 PM, the admission Director said she was responsible for getting residents admitted into the facility and would help them fill out their admission paperwork. She said she remembered Resident #1 when he was at the facility, and he admitted with hospice for a respite stay. She said on [DATE], he was admitted to the facility, and she helped him complete his admission paperwork and it was all electronic. She said he signed an OOH DNR on admission which was included in the admission paperwork. She said the hospice company arranged transport for him to get to the facility and he was adamant he wanted a DNR, and she explained to him what it was, and he signed it. She said he was alert and oriented x3. She said once the DNR was signed, she then gave it to the SW who would facilitate getting it signed by the physician. She said the SW would be responsible for informing the family that a DNR was signed and if one was not signed on admission, then the resident would be a full code which meant CPR would be performed. She said his wishes were to go (he was ready to die). She said the DNR was signed by the physician before he passed and was back in the facility. She said she never saw the family in the facility and only spoke to Resident #1 and the hospice company. She said the resident was able to make his needs known.During an interview on [DATE] at 4:45 PM, the Administrator said the facility had a signed OOH DNR for Resident #1 that was signed on his admission to the facility by him, the admission Director, and the physician. She said she was not sure why the signed DNR was not uploaded into Resident #1's chart. She said all staff were aware Resident #1 had a DNR but recognized there was a system failure when all involved were not aware he had one which included hospice or the family. She said the SW was out of the facility during that time, but the DNR was sent to the MD via fax, and it was signed and sent back to the facility. She said the resident was alert and oriented x3 and knew what he had signed. She said Resident #1 expired on [DATE] in the facility. During a phone interview on [DATE] at 5:18 PM, the MD for Resident #1 said he signed an OOH DNR for the resident electronically and it was signed before the resident expired at the facility.During an interview on [DATE] at 12:05 PM, the Administrator said the DON or designee was responsible for ensuring the medical records were updated and had the OOH DNR on file. She said the SW would be responsible for updating the care plan to reflect the code status and nurses had access to update them. She said Resident #1 had a DNR that was signed on admission but did not get uploaded into the system. She said they were going to implement that a weekend admission was followed up by the weekend RN supervisors. She said she expected the medical records to be accurate and finalized and fully completed for the residents. She said there was a risk of records not being updated and the staff would not have the full information or know if the correct information was being given to all staff.Record review of the facility policy titled Charting and Documentation, revised [DATE], indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.