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	04/21/2026

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 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. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of medications for 3 of 6 medication carts (medication cart for halls 400, 500, and 600, nurse cart for odd room numbers on hall 100 and 200, and medication cart for hall 100 and 200) reviewed for pharmacy services.The facility failed to remove (1) bottle of expired aspirin 325 mg and (1) box of arginaid powder (medication used to aid in wound healing) and a plastic bag of a white powder without a date from the medication cart for halls 100 and 200 on 4/20/2026.The facility failed to remove (1) box of arginaid powder from the medication cart for halls 400, 500, and 600 on 4/20/2026.The facility failed to remove an expired insulin vial of Humulin R 100 units/ml from the nurse cart for odd room numbers on hall 100 and 200 on 4/20/2026.These failures could place residents at risk for the unsafe administration of medications, not receiving prescribed doses of ordered medications and infection.Findings included:During an observation on 04/20/2026 at 7:43 am the medication cart for hall 100 and 200 with MA E revealed:*(1) bottle of aspirin 325 mg expired 1/2026 and was opened 7/24/2025*(1) clear, plastic bag of a white substance that says thickener with no date present.*(1) box of arginaid powder expired 4/2/2026 that had (9) packets with an open date of 12/29/2025During an interview on 4/20/2026 at 7:45 am, MA E said the ADONs were responsible for checking the medication carts periodically. She said she checked periodically for expired medications. She said if residents took medications that were expired the medicine would not be as effective. She said she was not aware the cart had expired items. She said the white powder was thickener used to thicken liquids for residents who had trouble swallowing. She said she never used the thickener, and it should have a date or label to indicate what was in the bag.During an observation on 4/20/2026 at 8:19 am the medication cart for halls 400, 500, and 600 with LVN F revealed:*(1) box of arginaid powder expired 4/12/2026During an interview on 4/20/2026 a6 8:22 am, LVN F said whoever was assigned the medication cart was responsible for checking it for expired medications. She said she checked the cart once a week. She said the arginaid was something that they no longer used and was not aware it had expired. She said residents could get sick and cause other issues if residents took medications past their expiration dates.During an observation on 4/20/2026 at 2:29 pm the nurse cart for odd room numbers on hall 100 and 200 with LVN G revealed:*(1) insulin vial of Humulin R 100 unit/ml dated 11/1/2023 with date opened 11/6/2023.During an interview on 4/20/2026 at 2:43 pm, LVN G said the Humulin R insulin was expired. She said the resident that took that insulin was in the secure unit and was not sure why she had insulin was in the cart. She said the unit had a separate medication cart. She said that insulin was good for 28 days after opening. She said if the medicine was given to a resident, it might not be as effective. She said the nurses were responsible for checking the medication carts daily every shift.During an interview on 4/21/2026 at 10:13 am, the ADON said medications carts should be checked periodically but daily by the nurses and med aides and should remove medications that were expired. She said the ADON's and DON checked them weekly. She said they checked the carts about a week ago. She said the thickener should have an attached label with a date. She said insulin was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	good for 28 days after opening and then should be replaced with a new one and dated. She said medications may not have the therapeutic effects that were intended if given past their expiration dates. During an interview on 4/21/2026 at 10:35 am, the DON said she along with the ADONs were responsible for checking the medication rooms and carts with random audits. She said the staff assigned to the carts should check them daily. She said audits were done by the DON and ADON's at least weekly in the rooms and carts. She said insulin was good for 28 days after opening and then should be discarded. She said medications might be ineffective if given past their expiration dates. During an interview on 4/21/2026 at 12:26 pm, the Administrator said the charge nurses along with the ADON/DON and Pharmacy consultant were responsible for checking the medication carts and medication rooms. She said residents could have a negative effect if medications were taken past their expiration dates. She said they would complete a 1:1 in-service with the staff involved along with group in-services. Record review of a facility policy titled Storage of Medications revised April 2019 indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety for facility's only kitchen reviewed for food storage. The facility did not ensure foods in the freezer and dry storage area were stored, labeled and dated when opened or removed from their original packaging or opened on 4/19/2026. This failure could place residents who received their meals from the kitchen at risk of food-borne illness.Findings included: During an observation in the facility kitchen on 04/19/26 at 9:50 AM, the dry storage area had the following:*a container labeled thickener, the lid was open and off center. *a plastic bag with yellow dry mix dated 4/18/26 but no label of contents.*a plastic bag with opened package labeled brown gravy mix with no open date or use by date.*a container of enchilada sauce with no open or use by date, half of contents missing and manufacturer's label of refrigerate after opening. During an observation in the facility kitchen on 04/19/26 at 10:00 a.m., the freezer had the following:* a plastic bag of corn which was undated, not labeled and holes in the bag. During an interview on 4/21/26 at 10:00 a.m., the CDM said it was the responsibility of all kitchen staff to inspect the freezers, refrigerators, and food storage areas for open, undated, or unlabeled food. She said any packages not labeled or dated should be discarded immediately. The CDM said she had signs posted in the kitchen to remind all staff to look for open, undated, or unlabeled food when checking refrigerator and freezer temperatures. She said food storage information is available to all staff and located in 2 areas of the kitchen. The CDM said the risk of improperly stored and/or labeled food was serving expired food to residents and increased risk of food-borne illness. The CDM said, going forward, she planned to conduct an in-service with all kitchen staff covering proper storage and labeling of food and opened items. During an interview on 4/21/26 at 11:00 a.m., the ADM said the CDM was responsible for supervising kitchen staff directly and she was responsible for oversight of ensuring all kitchen policies were followed. The ADM said the facility policy was all food stored in the facility kitchen should be dated, labeled, and sealed. The ADM said her expectation was that all staff follow the facility policy regarding labeling and storing food. The ADM said the risks to residents would be serving unpalatable food to residents or cause food borne illness. Review of a facility policy titled Food Storage, dated 2018, indicated .Open packages of food are stored in closed containers with covers or in sealed bags, and dated as when opened.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to personal privacy for 1 of 6 residents reviewed for resident rights. (Resident #64)The facility failed to ensure Resident #64 was treated with dignity and respect when the Treatment Nurse failed to provide privacy during wound care on 4/21/26.This failure could place residents at risk for feeling disrespected, a decreased sense of self-worth, and depression. Findings included:Record review of a facility face sheet dated 4/19/26 for Resident #64 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of displaced fracture of base of neck of left femur, subsequent encounter for closed fracture with routine healing (recovery after a displaced fracture of the base of the neck of the left femur - which occurs when the upper part of the femur, just below the hip joint, breaks and the bone fragments are misaligned from their normal position).Record review of Resident #64's electronic medical record reviewed on 4/21/26 indicated she had not been in the facility long enough to have a comprehensive MDS assessment completed.Record review of a baseline care plan dated 4/9/26 for Resident #64 indicated the baseline care plan did not address any current or historical skin integrity issues.During an observation and interview on 04/19/2026 at 11:24 am Resident #64 was observed lying in bed. She said she had been admitted to the facility for rehabilitation after having hip surgery for a broken hip. During an observation on 04/21/2026 at 8:45 am the Treatment Nurse was observed to perform wound care to a skin tear on Resident #64's right buttock. The Treatment Nurse did not pull privacy curtain, or close room door to provide privacy for Resident #64. During wound care while resident was rolled to right side with buttocks exposed, another staff member (male) walked in the open room door looking for Resident #64's roommate. At that time, the Treatment Nurse said Crap, I forgot to close the curtain. The male staff member exited the room after seeing the treatment in progress.During an interview on 04/21/2026 at 9:00 am the Treatment Nurse said she normally always closed the curtain. She said she realized as soon as the other staff member walked in. She said she was nervous because she was being watched and she just forgot. She said it could be embarrassing for the residents if privacy was not provided during treatments.During an interview on 04/21/2026 at 9:05 am Resident #64 said it was a little embarrassing for another staff member, especially a male, to walk in during her treatment to her buttocks.During an interview on 4/21/2026 at 1:25 pm the Administrator said she expected all her residents to be treated with dignity. She said they would be in-servicing staff to ensure all residents are provided with privacy when having care provided. She said it could be embarrassing for them.During an interview on 4/21/26 at 1:10 pm the DON said she expected her staff to treat all residents with dignity and provide privacy. She said she would educate all the staff to ensure compliance going forward. She said all residents have a right to privacy.Record review of a facility policy titled Resident Rights dated October 4, 2022, read: .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence . Record review of a facility policy titled Quality of Life - Dignity dated October 4, 2022, read: .Residents shall be treated with dignity and respect at all times . and .Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .

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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, interview, and record review the facility failed to ensure the resident's right to a safe, clean, and comfortable environment for residents for 1 of 24 residents (Resident #27) observed for resident environment.The facility failed to ensure the floor in Resident #27's room did not have standing water and was without odors from 4/19/2026-4/21/2026.These failures could place residents at risk for an unsanitary environment.Findings included:Record review of an admission Record for Resident #27 dated 4/21/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of cerebral infarction (stroke), malignant neoplasm of lung (lung cancer), major depressive disorder (persistent sadness or loss of interest in doing things), and dysphagia (difficulty swallowing).Record review of a Quarterly MDS Assessment for Resident #27 dated 3/11/2026 indicated he had severe impairment in thinking with a BIMS score of 5. He was dependent on staff to transfer from chair to bed.Record review of a care plan for Resident #27 revised 3/20/2024 indicated he had an ADL self-care performance deficit related to impaired balance. He required the use of a mechanical lift x2 staff for assistance with transfers.During an observation and interview on 4/19/2026 at 10:07 am, Resident #27 was in bed awake and said he had been at the facility for a long time. His bed was in a low position. The floor by his bed had standing water that was seeping from under the wall. Resident #27 said he was not aware his floor was leaking.During an observation and interview on 4/19/2026 at 10:10 am, CNA C was in the room of Resident #27 and said she was aware of the room having a water leak. She said it was coming from the shower room, and she reported it a month or so ago to the charge nurse verbally but was unable to recall who she reported it to.During an observation on 4/20/2026 at 7:20 am, the room of Resident #27 still had water standing on the floor by the wall and smelled like mold/mildew. Resident #27 was not in the room.During an observation on 4/20/2026 at 7:25 am, the shower room on hall 200 that was by Resident #27's room had two showers. The shower on the right side had an out of order sign on the shower that was dripping water hitting the floor going underneath the wall.During an observation on 4/20/2026 at 2:23 pm, in Resident #27's room, water was standing on the floor seeping in from underneath the wall.During an observation and interview on 4/20/2026 at 4:28 pm, CNA H was on the hall where Resident #27 resided. She said she worked the 2 pm-10 pm shift. She said she was aware of the leak in the room of Resident #27. She said it had been reported to the Maintenance Supervisor one day last week. She said the Maintenance Supervisor placed tiles down and placed an out of order sign in the shower room on the affected shower. She observed the shower room and the shower head on the right side of the room had an out of order sign, but the water was still running and hitting the floor. She said Resident #27's room floor stayed wet when they were in the room providing care. She said she would feel overlooked and neglected if it was her living in that room. She said she noticed the room had a water leak about 2 weeks ago before it was reported. During an observation and interview on 4/21/2026 at 7:31 am, CNA K was in Resident #27's room providing care. The floor had standing water coming from underneath the wall. She said the room had been leaking for about a week that she noticed and it was coming from the shower room on the other side of the wall. She said they were told not to use the shower on that side. She said it was reported to the Maintenance Supervisor and had been informed someone would be out to repair it. She said it would make her feel bad and it smelled weird like wet cats if she was a resident that had to live in that room.During an interview on 4/21/2026 at 8:02 am, the Maintenance Supervisor said in the shower room on hall 200 there was a gap under the wall by the shower and he had tried to put a seal and a baseboard to keep water from going underneath the wall. He said a plumber was scheduled to go to the facility that day. He said he had called them that morning. He said the room where Resident #27 resided was reported to him last week by a nurse aide. He said they did not tell him the shower was still running water. He (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said he would not want to live like that. He said staff reported issues in the logbook and other times it was verbally. He said now they had to put a work order in TELS (a system used to report maintenance issues) and that system was very new to him. He said the shower rooms had a faulty design where the floors were flat and should be angled at a slope for the water to drain into. He said he was doing the best that he could. During an interview on 4/21/2026 at 12:26 pm, the Administrator said she was not aware the shower room on hall 200 was leaking and the water was going into the room of Resident #27. She said staff were supposed to report maintenance issues to the charge nurse who would then place the request in TELS. She said a plumber was going to the facility that day to place a water barrier in the shower room. She said if she were a resident she would expect repairs to be fixed. Record review of a maintenance repair list for the facility dated 12/25/2025 to 3/29/2026 did not indicate a repair was needed for Resident #27's room.Record review of a facility policy titled Quality of Life-Homelike Environment revised May 2017, .Residents are provided with a safe, clean, comfortable and homelike environment .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents received care and services in accordance with professional standards of practice for 1 of 6 residents (Resident #64) reviewed for quality of care.The facility failed to ensure Resident #64's surgical site was monitored for signs and symptoms of infection each shift while a non-removable dressing was in place from 4/9/26 to 4/20/26.This failure could place residents at risk of not receiving appropriate care and treatment and/or decline in their health.Findings include:Record review of a facility face sheet dated 4/19/26 for Resident #64 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of displaced fracture of base of neck of left femur, subsequent encounter for closed fracture with routine healing (recovery period after a displaced fracture of the base of the neck of the left femur - which occurs when the upper part of the femur, just below the hip joint, breaks and the bone fragments are misaligned from their normal position).Record review of Resident #64's electronic medical record 4/21/26 indicated she had not been in the facility long enough to have a comprehensive MDS assessment completed.Record review of a baseline care plan dated 4/9/26 for Resident #64 indicated the baseline care plan did not address any current or historical skin integrity issues.During an observation and interview on 04/19/2026 at 11:24 am Resident #64 was observed lying in bed. She said she had been admitted to the facility for rehabilitation after having hip surgery for a broken hip. She said the staff had not changed the dressing on her hip since admission on [DATE]. Observation of a dressing to Resident #64's left hip indicated a date of 4/17/26. She said she had an appointment with the surgeon on Tuesday 4/21/26.Record review of a physician's order report for Resident #64 dated 4/1/26 through 4/30/26 indicated she had the following order: .Wound care: Change aquacell dressing to left hip surgical site area and then apply new aquacell dressing to left hip surgical site area one time only for surgical incision. dated 4/17/26. There was no order in place to monitor site for redness, excess drainage, to ensure no excess drainage to dressing, or signs/symptoms of infection.Record review of a Treatment Administration Record dated 4/1/26 through 4/30/26 for Resident #64 indicated there was no documentation of monitoring surgical area for signs/symptoms of infection.During an interview on 04/20/2026 at 11:29 am the Treatment Nurse said there should always be an order in place to monitor a wound or surgical incision each shift for signs/symptoms of infection. She said if a staff member did not see the order on the MAR or TAR, they may not know they need to monitor the incision area or wound for any signs/symptoms of infection and the resident may exhibit signs/symptoms without having interventions and they could develop an infection.During an interview on 04/21/2026 at 1:00 pm the Administrator said she expected staff to follow policies and procedures when admitting residents' post-surgery. She said residents might be at risk of infections if they were not monitored. She said she would be in-servicing staff to ensure compliance going forward. During an interview on 4/21/26 at 1:10 pm the DON said the surgical incision should have been documented and orders put in place to monitor for signs/symptoms of infection. She said it should have been ordered so it would show up on the TAR for nurses to do and document. She said the resident could have developed an infection and not been caught in time. She said she and the ADONs would be monitoring new admissions going forward to ensure everything was in place. Record review of a facility policy titled Surgery-Related (Pre- and Postoperative) Management - Clinical Protocol dated October 2010 read: .The staff and physician will monitor for, and address, postoperative risks and complications such as infection, deep vein thrombosis, cardiac arrhythmia, bleeding, failure of surgical wounds to heal .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 1 of 1 facility (3 of 7 mechanical lift slings) reviewed for hazards:The facility failed to remove faded, worn and damaged mechanical lift slings from service. This failure could result in a loss of quality of life due to injuries. Findings included:During an interview and observation of the facility laundry on 04/20/2026 2:30 PM the Laundry Supervisor said she washed the lift slings and hung them up to air dry. Three of the seven mechanical lift slings hanging on the wall racks drying in the clean linen area had faded straps, light in color (light gray, light teal and light purple) not bright and vivid colors as the other mechanical lift slings hanging on the rack. One of the mechanical lift slings care label was faded and attached by a few threads of stitching. The Laundry Supervisor said she had new mechanical lift slings and would replace the 3 damaged lift slings. She said she considered the three lift slings still useable. She said that if a lift sling broke it could cause a fall with injury. During an observation and interview on 04/20/26 at 4:00 PM the Administrator observed the 3 mechanical lift slings. She said the risk to the resident was injury if the lift sling broke during transfer and cause a fall. The Administrator said she would remove the damaged slings from service, and she had replacements already in the facility. The Administrator said the nursing staff must be pulling the damaged slings from closets, because they had just completed a sweep and replaced worn- damaged slings. She said that if the lift sling broke it could cause a fall with injury. During an interview on 04/21/2026 at 10:00 am the Housekeeping Supervisor said she was responsible for housekeeping and laundry service for the facility. She said she and the laundry techs are responsible for pulling the damaged and faded mechanical lift slings from service. She said she would remove the damaged/faded lift slings and replace them with new ones. She said there was a risk of the straps breaking and a fall if damaged lift slings were left in service. She said she trains her laundry technicians and will provide them with additional training. During an interview on 04/21/26 at 1:45 PM, the DON said the straps on the three mechanical lift slings were faded. She said she in serviced nursing staff when to remove lift slings from service. The DON said the straps could break on damaged lift slings and cause a fall with resulting injuries. Record review of a facility policy titled Quality of Life-Homelike Environment revised May 2017, .Residents are provided with a safe, clean, comfortable and homelike environment .Record review of manufacture guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 04/20/26 read .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Missing or illegible care labels. Any slings with signs of wear or improper laundering should be immediately removed from use .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent infections and to restore continence to the extent possible for 1 of 5 (Resident #7) residents observed for urinary catheter (tube placed in the bladder that drains into a bag outside of the body) care.LVN D did not provide appropriate catheter care for Resident #7 when she did not use the proper cleaning agent or clean the catheter tubing on 4/21/2026.This failure could place residents at risk for bacterial infections from improper catheter care. Findings include:Record review of an admission Record for Resident #7 dated 4/21/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of hemiplegia (paralyzed on one side of the body), COPD (a group of lung diseases that affect breathing), type 2 diabetes, and chronic kidney disease (a condition where the kidneys are damaged).Record review of a Significant Change MDS Assessment for Resident #7 dated 4/3/2026 indicated she had moderate impairment in thinking with a BIMS score of 11. She was dependent on staff for toileting hygiene. She had an indwelling catheter, and she was always incontinent of urine/bowel. Record review of a care plan for Resident #7 dated 4/19/2026 indicated she was on EBP related to MDRO and had an indwelling medical device.Record review of active physician orders for Resident #7 dated 4/21/2026 indicated an order for catheter: urinary catheter provide care with approved cleaning agent every shift with soap and water or may use wipes as appropriate/desired by patient with a start date of 3/27/2026.During an observation on 4/21/2026 at 4:10 pm, LVN D was in the room of Resident #7 to provide urinary catheter care. She donned a gown in the hallway and sanitized her hands and placed gloves on them. She had a bottle of normal saline and 4x4's in a plastic cup. She entered the room and placed the cup and bottle of normal saline on the over bed table. She opened the resident's brief and poured normal saline on the gauze that was in the plastic cup. She removed gauze from the cup and cleaned the catheter tubing at insertion site in a downward motion twice and placed the gauze in the trash. She did not clean down the tubing. She removed her gloves and placed them in the trash. She doffed (removed) her gown in the room and placed it in the trash and washed her hands.During an interview on 4/21/2026 at 4:22 pm, LVN D said she was taught to clean the catheter tubing at the point of contact until she reached the meatus (body opening). She said she was not taught to clean down the tubing. She said there could be a risk of residents getting UTI's if proper procedures were not followed. During an interview on 4/21/2026 at 10:13 am, the ADON said when urinary catheter care was provided staff should use a wipe and clean from insertion down the tubing about 3-4 inches. She said staff should use incontinent care wipes or soap and water with a washcloth when urinary catheter care is provided and it should be done every shift. She said if staff did not it could place residents at risk of infections.During an interview on 4/21/2026 at 10:35 am, the DON said she along with the ADON's were responsible for training staff on hire and annually and as needed. She said urinary catheter care should be done at least every shift and as needed. She said they should use an appropriate solution like wipes or soap and water with a washcloth. She said they should clean at least four inches down the tubing. She said she planned to conduct refresher training with all staff. She said residents could be at risk of infections if they did not follow proper policy.During an interview on 4/21/2026 at 12:26 pm, the Administrator said staff were trained on hire and annually by the ADON or designee on skills. She said she expected staff to follow proper procedures and facility policy to prevent infection control issues.Record review of a facility policy titled Catheter Care, Urinary revised January 3, 2023, indicated, .The purpose of this procedure is to prevent catheter-associated urinary tract infections. 17. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward .

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	455673	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood IN the Pines	902 Hill Street Lufkin, TX 75904

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 6 staff (CNA C and LVN D) and 2 of 5 resident (Resident #5 and Resident #7) reviewed for infection control.1.The facility failed to ensure CNA C washed or sanitized her hands between glove changes and did not touch clean items with dirty gloves when incontinent care was provided to Resident #5 on 4/19/2026.2.The facility failed to ensure LVN D washed or sanitized her hands between gloves changes during urinary catheter care to Resident #7 on 4/21/2026These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:1. Record review of an admission Record for Resident #5 dated 4/19/2026 indicated she admitted to the facility 12/16/2021 and was [AGE] years old with diagnosis of COPD (a group of lung diseases that affect breathing), type 2 diabetes, atrial fibrillation (an irregular heart rhythm), and heart failure (the heart is not able to pump effectively).Record review of a Quarterly MDS Assessment for Resident #5 dated 3/6/2026 indicated she did not have any impairment in thinking with a BIMS score of 12. She was dependent on staff for personal hygiene and always incontinent of urine and bowel.Record review of a care plan for Resident #5 dated 11/7/2024 indicated she had bowel and bladder incontinence. Interventions included checking every two hours and as required for incontinence. During an observation on 4/19/2026 at 3:34 pm, CNA C was in the room of Resident #5. She had a plastic bag and a package of wipes in her hands and placed the bag on the floor and the wipes on the bed. CNA C washed her hands in the room and placed gloves on both hands. She opened the resident's brief and placed it between her thighs. She removed wipes and wiped them across the resident's lower abdomen and then down the middle of her vagina and placed the wipes inside the brief. She removed more wipes and wiped down the middle of the vagina from front to back and placed the wipes inside the brief. CNA C removed her gloves and placed them in the trash. CNA C removed gloves from her pocket and placed them on her hands. Resident #5 was rolled onto her right side, and her brief was removed and placed in the trash. CNA C placed a clean brief under the resident's buttocks. CNA C removed wipes from the package and wiped the perineal area from front to back and placed the wipes in the trash. CNA C secured the brief and repositioned the resident in bed. CNA C removed her gloves and placed them in the trash. CNA C washed her hands in the room and placed the trash in the bin that was in the hallway. CNA C placed the package of wipes on n the cart in the hallway.During an interview on 4/19/2026 at 3:41 pm, CNA C said she had been working at the facility for 6 months. She said during the care provided to Resident #5, after she removed her gloves, she should have sanitized or washed her hands. She said gloves should have been on the bedside table on a clean surface and not in her pocket. She said each resident should have a package of wipes in the room and the wipes should not have been placed back on the cart after they were taken into the room. She said before she grabbed the clean brief, she should have removed her gloves and washed or sanitized them before she touched it. She said the DON observed her with a competency skills check off. She said residents could be at risk of cross contamination or infections if staff did not follow proper procedures and protocols. Record review of a competency assessment for perineal care for CNA C dated 12/15/2025 indicated competency was demonstrated and observed by the DON. 2. Record review of an admission Record for Resident #7 dated 4/21/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of hemiplegia (paralyzed on one side of the body), COPD (a group of lung disease that affect breathing) type 2 diabetes, and chronic kidney disease (a condition where the kidneys are damaged).Record review of a Significant Change MDS Assessment for Resident #7 dated 4/3/2026 indicated she had moderate impairment in thinking with a BIMS score of 11. She was dependent on staff for toileting hygiene. She had an indwelling catheter (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and was always incontinent of urine/bowel. Record review of a care plan for Resident #7 dated 4/19/2026 indicated she was on EBP related to MDRO and had an indwelling medical device.During an observation on 4/21/2026 at 4:10 pm, LVN D was in the room of Resident #7 to provide urinary catheter care. She donned a gown in the hallway and sanitized her hands and placed gloves on them. She had a bottle of normal saline and 4x4 gauze in a plastic cup. She entered the room and placed the cup and bottle of normal saline on the over bed table. She opened the resident's brief and poured normal saline on the gauze that was in the plastic cup. She removed saline soaked gauze and cleaned the catheter tubing at insertion site in a downward motion and placed the gauze in the trash. She removed her gloves and placed them in the trash and did not wash or sanitize her hands before she applied clean gloves. She removed more gauze from the cup and cleaned the tubing again in a downward motion. She removed her gloves and placed them in the trash and did not wash or sanitize her hands and placed clean gloves on her hands. She doffed (took off) her gown in the room and placed it in the trash and washed her hands.During an interview on 4/21/2026 at 4:22 pm, LVN D said during the care provided to Resident #7 she should have washed or sanitized her hands between glove changes. She said she had sanitizer on her cart and got nervous and forgot. She said there could be a risk of residents getting UTI's if proper procedures were not followed. During an interview on 4/21/2026 at 10:13 am, the ADON said the ADON's conducted training on hire and annually on infection control and hand hygiene. She said hand hygiene should be done before care, between glove changes, before going from touching dirty items to clean, and when was completed with soap and water or hand sanitizer. She said when staff change gloves they should wash or use sanitizer. She said residents could be at risk of infections. She said she planned to have a 1:1 education with LVN D and in-services with the other nurses as well.During an interview on 4/21/2026 at 10:35 am, the DON said she along with the ADON's were responsible for training staff on hire, annually, and as needed on infection control and hand hygiene. She said hand hygiene should be done before care, when hands were visibly soiled, after care, and between glove changes. She said staff could use sanitizer or wash their hands. She said staff should never touch clean items with dirty gloves. She said she planned to conduct refresher training with all staff. She said residents could be at risk of infections if they did not follow proper policy.During an interview on 4/21/2026 at 12:26 pm, the Administrator said staff were trained on hire and annually by the ADON or designee on skills. She said she expected staff to follow proper procedures and facility policy to prevent infection control issues.Record review of a Handwashing/Hand Hygiene revised December 22, 2023, indicated, . This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub containing at least 60-90% alcohol; or, alternatively, soap and water for the following situations: g. before handling clean or soiled dressings, gauze pads etc.; m. After removing gloves .

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Parkwood IN the Pines	902 Hill Street Lufkin, TX 75904

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 dining area reviewed for environmental concerns. 1. The facility failed to ensure the dining room ceiling was in good repair and without damage and peeling paint. 2. The facility failed to ensure the dining room lighting and ceiling were free from thick cobwebs and dust. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.Findings include: During observations on 04/19/26 at 12:00 PM revealed the following:*thick cobwebs and dust were noted to the chandelier and extending to the ceiling in the center of the main dining area located above resident dining tables. an area of loose peeling paint was noted to the ceiling located between center island area of the main dining room and resident dining table. During an interview on 04/21/2026 at 10:30 AM, the Housekeeping Supervisor said she was unsure of who would be responsible for cleaning the chandelier in the dining area. She said due to the height of the ceiling that maintenance would have to assist due to needing a ladder to reach the area. She stated maintenance would be responsible for removing chipped paint and repairing the area had peeling paint to the ceiling. During an interview on 04/21/26 at 11:00 AM, the Administrator said maintenance and housekeeping would be responsible for cleaning the chandelier in the dining room. She stated that it had not been part of the cleaning routine at the time of the interview. She stated that she was aware of some areas from old leaks but was not aware of peeling paint. She said that the areas would be repaired. She said she wasn't sure how the cobwebs and small area of peeling paint would affect the residents. Record review of the facility's policy titled Quality of Life - Homelike Environment, dated May 2017, indicated, .the facility staff and management shall maximize to the extent possible the characteristics of the facility that reflect a personalized setting, homelike setting. These characteristics include: clean, sanitary and orderly environment

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 1 of 3 days reviewed (4/19/26) for nurse staffing posting.The facility failed to post the daily staffing information in a prominent place on 4/19/26. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts.Findings included:During an observation on 4/19/26 at 9:30 am upon entrance to the facility, the daily staff posting was not observed in the main entrance lobby.During an observation on 4/19/26 at 10:00 am during initial rounds of the facility, the daily staff posting was not observed at or near the nurse's station for 400/500/600 hallways.During an observation on 04/19/2026 at 3:30 pm the daily staff posting was observed posted at each side of the facility near both nurses' stations. Posting was located on a short, side hall near staff offices. It was not in a prominent location. During an interview on 04/21/2026 at 1:00 pm the Administrator said she would be making the night charge nurse responsible for the daily staff posting. She said she could not think of any negative outcomes related to the daily staff posting not being in a prominent location. Record review of a facility policy titled Posting Direct Care Daily Staffing Numbers undated read: .Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format .