STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455690	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parks Health Center	111 Parks Village Dr. Odessa, TX 79765

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring and administering of all medications to meet the needs of each residents, for 1 of 4 medication carts inspected for controlled medication reconciliation and for 2 of 10 (Residents #24 and #46) residents reviewed for pharmacy services in that: MA B did not document the administration of a controlled medication on the individual controlled medication records after administering it to Residents #12, #13, #15, #21 and #42 on 01/14/2026. MA A failed to administer prescribed medications to Resident #24 and #46 on 1/13/26 when she left medications at bedside unattended. This failure could place residents at risk for medication overdose, medication under-dose, drug diversion and placed residents at risk of not receiving therapeutic doses of prescribed medications.The findings included: RESIDENT #12 Record review of Resident #12's admission record, dated 01/14/2026, indicated she was admitted to the facility on [DATE] with diagnosis of pain. She was [AGE] years of age. Record review of Resident #12's order summary report active orders as of: 01/14/2026 indicated in part: Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth four times a day for Pain. Record review of Resident #12's Hydrocodone-Acetaminophen controlled medication record indicated 42 pills and the blister pack had 41 pills. RESIDENT #13 Record review of Resident #13's admission record, dated 01/14/2026, indicated she was admitted to the facility on [DATE] with diagnosis of anxiety disorder. She was [AGE] years of age. Record review of Resident #13's order summary report active orders as of: 01/14/2026 indicated in part: Clonazepam Tablet 0.5 MG Give 1 tablet by mouth 1 time daily and give 2 tablets (1mg) by mouth every day at bedtime. (Clonazepam is a medication used to treat anxiety). Record review of Resident #13's clonazepam controlled medication record indicated 28 pills and the blister pack had 27 pills. RESIDENT #15 Record review of Resident #15's admission record, dated 01/14/2026, indicated she was admitted to the facility on [DATE] with diagnosis of pain. She was [AGE] years of age. Record review of Resident #15's order summary report active orders as of: 01/14/2026 indicated in part: Tramadol oral Tablet 50 MG Give 1 tablet by mouth four times a day for pain. Record review of Resident #15's Tramadol controlled medication record indicated 12 pills and the blister pack had 11 pills. RESIDENT #21 Record review of Resident #21's admission record, dated 01/14/2026, indicated she was admitted to the facility on [DATE] with diagnosis of pain. He was [AGE] years of age. Record review of Resident #21's order summary report active orders as of: 01/14/2026 indicated in part: Acetaminophen-Codeine Oral Tablet 300-60 MG Give 1 tablet by mouth two times a day for Pain. Record review of Resident #21's Acetaminophen-Codeine controlled medication record indicated 32 pills and the blister pack had 31 pills. RESIDENT #42 Record review of Resident #42's admission record, dated 01/14/2026, indicated she was admitted to the facility on [DATE] with diagnosis of anxiety disorder. She was [AGE] years of age. Record review of Resident #42's order summary report active orders as of: 01/14/2026 indicated in part: Xanax Oral Tablet 0.5 MG (Alprazolam) Give 1 tablet by mouth two times a day related to otherspecified anxiety disorders. (Xanax medication to treat anxiety). Record review of Resident #42's Alprazolam controlled (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication record indicated 12 pills and the blister pack had 11 pills. During an observation and interview on 01/14/2026 at 10:22 AM the medication cart for hall 2 was inspected with MA B present. The controlled medication count for Residents #12, #13, #15, #21 and #42 were found to be incorrect. MA B said she had not signed them out yet and was going to do that later. MA B said she was supposed to sign the medication out as soon as she administered it. MA B said she was in a hurry this morning and did not sign the medication after she admitted them. MA B said her not doing that could lead to a discrepancy during reconciliation of the medications. During an interview on 01/14/2026 at 3:20 PM the ADON said the expectation was for the staff to sign the medication out on the controlled medication book as soon as it was administered. She said the staff should sign the medication out at the time they poured the medication as they might forget to sign it out later. The ADON said if the staff had to leave, the medication count would be incorrect. The ADON said that every morning they would check the controlled medication books to make sure the controlled medications were accounted for. During an interview on 01/15/2026 at 3:48 PM the DON said it was expected for staff to document whenever a controlled medication was administered ASAP. The DON said if the medication was not signed out it could possibly lead to a resident receiving another dose. The DON said that this failure probably happened because the staff were in a hurry and did not sign the medication out right away. The DON said the ADON would check the controlled medication book every morning. During an interview on 01/15/2026 at 4:00 PM the Administrator said it was his understanding that whenever a controlled medication was administered it was supposed to documented on the controlled medication book at that time and not later. The Administrator said that if the controlled medication was not signed as given right away it could possibly lead to medications being stolen. The Administrator said the failure probably occurred because the staff got in a hurry and did not take the time to document the medication as soon as it was administered. The Administrator said the ADON would check the controlled medication book every morning. Medication Unsupervised Resident #24Review of Resident #24 admission Record, dated 1/15/26, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included Alzheimer's Disease (neurological disorder causing loss of memory), hypoosmolality (sleeping too much), and hyperlipidemia. Review of Resident #24's Quarterly MDS Assessment, dated 1/1/26 revealed:She had a BIMS score of 13 of 15. (indicating she was cognitively intact) Review of Resident #24's Order Summary, dated 1/15/26, revealed orders:Atorvastatin 20mg (medication to control cholesterol) at bedtime for hyperlipidemiaDonepezil 10 mg (medication to slow symptoms of Alzheimer's disease) at bedtime for dementiaMelatonin 5 mg (supplement to assist with at bedtime for insomnia. There was no order for self-administration. Observation on 1/13/26 at 7:03 p.m. revealed a cup of 3 pills on Resident #24's bedside table. Interview on 1/13/26 at 7:11 p.m. the DON stated she did not know what the pills were, but she would find out. Interview on 1/13/26 at 7:17 p.m. with MA A and the DON, the MA stated Resident #24 usually takes it independently. The DON returned and stated the medications were Donepezil 10 mg, Atorvastatin 20 mg, and Melatonin 5 mg. MA A stated she knew better than to leave the medications unattended. Resident #46 Review of Resident #46's admission Record, dated 1/15/26, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included neuropathy (nerve disfunction causing pain) and Hyperlipidemia. Review of Resident #46's Quarterly MDS Assessment, dated 12/15/25, revealed:Her BIMS score was 15 of 15 (indicating she was cognitively intact). Review of Resident #46's Order Summary, dated 1/15/26, revealed orders:Atorvastatin 80 mg at bedtime for hyperlipidemia beginning 8/7/25.Gabapentin 600 mg (medication used to control nerve pain) 1 tablet at bedtime beginning 8/7/25. There was no order for self-administration. Observation and interview on 1/13/26 at 7:25 p.m. Resident #46 had a cup of 2 pills in a medication cup on the bedside table. MA A told the DON was medication was Gabapentin and Atorvastatin. MA A stated she could not give an excuse she knew better. The DON was aware and stated the medications should not be there. Interview on 1/13/26 at 7:30 p.m. with the Administrator and DON the Administrator stated he understood the medications left out were an issue. Review of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility's policy and procedure on General Medication Administration, undated revealed:Purpose: Safely and accurately administer physician-ordered medication to each resident. Record review of the facility's undated policy titled Controlled medication counting and logging revealed in part: Policy statement: The facility maintains strict controls over all controlled medications to ensure resident safety, prevent diversions, comply with federal and state regulations and maintain accurate accountability. All controlled medications shall be counted, documented, stored, administered and reconciled according to this policy. Shift-to-shift controlled drug count, counts are conducted at every shift change and cart handoff by the off-going and on-coming nurse together. Administration documentation - controlled medications must be documented immediately after administration on the MAR/eMAR and controlled log.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assure drugs and biologicals were stored properly in 1 of 2 medication rooms and failed to store all drugs and biologicals in locked compartments for 1 of 2 treatment carts and 1 of 4 medications carts in that: The refrigerator in the medication room contained 1 opened multi-use vial of Tuberculin PPD (Purified Protein Derivative) that had been opened but no open date was found on it. The treatment nurse failed to ensure the treatment cart was locked when it was left unattended. MA A failed to ensure the medication cart was locked when it was left unattended. These failures could place clients at risk for drug diversion or accidental ingestion and place residents and staff at risk for not getting an accurate screening for Tuberculosis.Findings included: During an observation on [DATE] at 9:03 AM the treatment cart was seen unlocked and unsupervised. The cart contained several treatment supplies such as betadine, ointments, wound care supplies and other items During an interview on [DATE] at 3:02 PM the treatment nurse said she had left to go to the restroom and had left the treatment cart unlocked. The treatment nurse said if the cart was left unlocked and unattended there could be a possibility of a resident getting into the items that were in the cart. During an observation and interview on [DATE] at 9:11 AM the front medication room for halls 1, 2 and 3 was inspected with MA A present. Inside the medication refrigerator was an open vial of Tuberculin and an open date was not found on the vial nor the box. The TB container indicated Once entered, vial should be discarded after 30 days. The MA said she did not administer the TB tests so she would not know anything about the vial not dated. During an observation and interview on [DATE] at 3:35 PM the medication cart for hall 2 and 3 was unlocked and unsupervised. The ADON was made aware and the cart was inspected with the ADON present. Inside the medication drawers were several bottles and bubble packs that contained several medications. The ADON said the medication carts were supposed to be locked if left unattended. The ADON said if the cart was left unlocked and unsupervised a resident could get into the cart and take some of the medications. During an interview on [DATE] at 3:44 PM MA A said she was not aware that she had left the medication cart unlocked. MA A said she usually locked her cart when she stepped away but had forgotten today. The MA said if the cart was left unlocked and unattended then a resident or unauthorized staff could have access to the medications. During an interview on [DATE] at 3:40 PM the DON said it was expected for staff to lock their medication carts when not in use. The DON said if the cart was left unlocked it could lead to a confused resident having access to it or also anyone else could have access to it. The DON said the carts were left unlocked and unattended probably because staff were not paying attention after stepping away from the cart. The DON said they monitored the medication carts throughout the day to make sure they were being locked. The DON said it was expected for the TB solution to be dated when opened to know when it was expired. The DON said the failure probably occurred because someone was in a hurry and did not take the time to date it. The DON said that the ADON inspected the medication room on a daily basis for expired or undated medications. During an interview on [DATE] at 4:04 PM the Administrator said it was expected for staff to lock their medication cart if they were not going to use it. The Administrator said that if the carts were left unlocked and unattended it could possibly lead to a resident getting the items in the cart and cause an injury. The Administrator said the failure probably occurred because the staff got nervous due to the state being in the facility as that would not happen when the state was not in the facility. The Administrator said that the DON, ADON and him performed daily rounds to monitor the facility which included the medication carts. The Administrator said it was expected for staff to date medications when they were opened so they would know when it was expired. The Administrator said the ADON checked the medication room and removed any expired or undated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications. Record review of the facility's undated policy titled Storage of medications revealed in part: Purpose: Ensure that medications are stored in a safe, secure and orderly manner. Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not to be left unattended. Compartments include but are not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes. Multi-dose vials that have been opened or accessed should be dated and discarded within 28 days of opening/initial access unless the manufacturer specifies a shorter or longer date. Record review of the facility's undated policy titled Medication Administration, General revealed in part: Keep the medication cart in view at all times. Lock the cart when not standing next to it or working from it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food prepared by methods that conserve nutritive value, flavor and appearance and food and drink that was palatable, attractive and at a safe and appetizing temperature from 61 of 63 residents in the facility. 1. The facility failed to ensure food was not held on the steam table longer than necessary for meal service. 2. The facility failed to ensure pureed foods were prepared according to recipes provided by the dietitian and cooked with large volumes of water. These failures could place residents at risk of weight loss, altered nutritional status, and diminished quality of life. Findings include: Observation and interview on 01/13/2026 at 9:47 AM revealed two metal containers of cooked broccoli on the steam table. [NAME] C stated the broccoli was for lunch. [NAME] C said the hallway trays were plated at 11:45 AM. Observation and interview on 01/14/2026 at approximately 11:14 AM revealed [NAME] C placed water into the puree blender. She did not measure the water. [NAME] C used the water to puree the meat item-ham. [NAME] C repeated the steps, using unmeasured water to puree mixed greens and sweet potatoes. [NAME] C said she used water to puree everything because the facility did not have recipes for pureed foods. [NAME] C said she judged the thickness by eyeing it. Interview with the Dietary Manager on 01/14/2026 at approximately 11:22 AM, revealed the Dietary Manager said his expectations for placing food on the steam table were: 15 minutes before a meal was served was best and 30 minutes was too early. The Dietary Manager said 30 minutes or longer will alter taste, texture, and nutritional value. Interview with the Dietitian on 01/14/2026 at approximately 11:26 AM, revealed the Dietitian said the facility had recipes for pureed food and using only water would have less nutritive value than following the recipes. Interview with the DM on 01/15/2026 at 3:07 PM, the DM said he had the recipe book for pureed items, and the staff had access to it. The DM said the outcome of using water only for pureed foods would be less nutritional benefits for the residents on pureed diets. He said this could lead to weight loss and malnutrition. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 06/19/2025 revealed: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers .(B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement .Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.

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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 and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation and food storage. 1. The facility failed to ensure temperatures were recorded for the refrigerators, dry storage, warmer oven, and freezers. 2. The facility failed to ensure stored foods were properly stored, labeled, and dated. 3. The facility failed to ensure dietary staff properly wore facial hair restraints. 4. The facility failed to properly clean the blender used to puree food between uses. 5. The facility failed to discard spoiled/out-of-date items. 6. The facility failed to prevent dishes and utensils from being stored face up (open to air contamination). 7. The facility failed to ensure Dietary Staff used proper hand hygiene. These failures could place residents at risk for food-borne illnesses.Findings include: Observation during the initial tour of the kitchen on 01/13/2026 at 9:10 AM, revealed the following:The Dietary Manager had a beard cover on that did not cover his mustache. Refrigerator 1 (next to the ice machine)-the temperature log posted was for December/2025-a pitcher contained a pink liquid without a label/date. Dry Storage-the temperature log posted was for January/2026 and was blank-a brown bag of powdered sugar was opened and not sealed-a brown bag of flour was opened and not sealed-baking soda with an expiration month and day was smeared off, expiration year was 2025-instant dry milk was opened and not sealed-toasted oats cereal was opened and not sealed-frosted flakes cereal was opened and not sealed-crispy rice cereal was opened and not sealed Kitchen-the posted food warmer temperature log was for January/2026 and was blank-serving/cooking utensils and pans were hanging from hooks, open to air, at the end of the steam table-plate covers were faced up, open to the air-steak seasoning spice, opened 4/14/2024 with the expiration date rubbed off-cilantro spice opened 1/20/2024, with best by date 7/30/2025-small disposable bowls and the lids faced up, open to the air-bin of blenders were open to air-2 tea dispensers were faced up and opened to the air-silverware in carrier was opened to the air Serving Line Refrigerator- the temperature log posted was for December/2025-a bag of romaine lettuce had turned brown-a tray of disposable cups with lids contained a white substance and did not have a label or date-a tray of disposable cups with lids contained a green substance and did not have a label or date-grated cheese with an opened date of 1/9/2026 and was not sealed-boiled eggs were not labeled and not dated-a metal bin of sliced jalapenos was not covered Walk-in Refrigerator-a metal bin labeled dinner and dated 1/6/2026, had no use by date-Swiss cheese slices opened 1/7/2026 and were not sealed-a metal bin of fruit cocktail was dated 1/8/2026 During the second observation of the kitchen on 1/14/2025 at approximately 11:07 AM, revealed the following: -The Dietary Manager had a beard cover that did not cover his mustache. -Dietary Aide E returned from outside the kitchen with gloves on. Dietary Aide E did not remove the gloves and perform hand washing. -While plating the food, [NAME] C used the same tongs to plate the meat item-ham and the baked potatoes. In an interview with the Dietary Manager on 01/15/2026 at 3:07 PM, he said there was not a good excuse for all the issues/concerns noted in the kitchen. He said the previous Dietary Manager who was fired 3 weeks ago, had allowed the staff to get lazy and run things however they wanted. The DM said he was having to combat bad behaviors, bad attitudes, and negativity. The DM said the residents were at risk of illness due to spoiled food and cross contamination. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 06/19/2025 revealed: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers .(B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement .Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.

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	455690	A. Building B. Wing	01/15/2026

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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 observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 6 residents (Resident #15 and Resident #29) reviewed for care plans. The facility failed to develop a comprehensive person-centered care plan regarding oxygen therapy for Resident #15 and Resident #29. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services. Findings include: 1. Record review of Resident #15's admission record, dated 01/15/2026, revealed a [AGE] year-old female with an original admission date to the facility of 07/26/2021 and re-admission on [DATE]. The admission record revealed Resident #15 had diagnoses which included congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), muscle weakness, emphysema (a lung disease that results from damage to the walls of the alveoli in your lungs), and shortness of breath. Record review of Resident #15's Quarterly MDS assessment, dated 12/31/2025, revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Section O of the MDS revealed Oxygen Therapy was selected for use while a resident of the facility. Record review of Resident #15's Care Plan, dated 01/15/2026, revealed oxygen was not included in the Care Plan. Record review of Resident #15's order summary, dated 01/16/2026, revealed no orders for oxygen therapy. Observation on 01/13/2026 at 3:14 PM revealed Resident #15 was not in her room. The oxygen concentrator was set at 2.5 liters per minute. Observation and interview on 01/13/2026 at 4:21 PM revealed Resident #15 was in her room with a nasal canula on and the oxygen concentrator on, set at 2.5 liters per minute. Resident #15 said she had to wear oxygen, or she had trouble breathing. Observation on 01/15/2026 at 8:17 AM revealed Resident #15 was asleep in a wheelchair with the nasal canula on and the oxygen concentrator on, set at 2.5 liters per minute. 2. Record review of Resident #29's admission record, dated 01/15/2026, revealed a [AGE] year-old female with an original admission date to the facility of 03/14/2023 and re-admission on [DATE]. The admission record revealed Resident #29 had diagnoses which included asthma (a chronic lung disease characterized by inflammation and narrowing of the airways, making it difficult to breathe), dyspnea (difficult or labored breathing), hypoxemia (low levels of oxygen in the blood), and shortness of breath. Record review of Resident #29's Initial MDS assessment, dated 01/02/2026, revealed the resident had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. Section O revealed Oxygen Therapy was selected for use while a resident of the facility. Record review of Resident #29's Care Plan, dated 01/15/2026, revealed oxygen was not included in the Care Plan. Record review of Resident #29's order summary, dated 01/16/2026, revealed no orders for oxygen therapy. Observation on 01/13/2026 at 11:24 AM revealed Resident #29 was wearing a nasal canula and oxygen concentrator , set at 4.0 liters per minute. Observation on 01/15/2026 at 2:08 PM revealed Resident #29 was in bed with nasal canula on and oxygen concentrator on, set at 4.0 liters per minute. During an interview with the DON on 01/15/2026 at 4:10 PM, the DON said she was responsible for ensuring the Care Plans were accurate. The DON said she was not aware the oxygen for both residents was not ordered and was not care planned. The DON said oxygen not being ordered or care planned could cause the residents to not receive adequate oxygen therapy, causing shortness of breath and confusion due to inadequate oxygen levels in the blood. Record review of the facility's, undated, policy titled Respiratory Care revealed 1. A comprehensive assessment will be completed on each resident within 14 days of admission to this facility and periodically as required, including when a significant clinical change in status is identified. 2. The interdisciplinary team, along with the (continued on next page)

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	455690	A. Building B. Wing	01/15/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident/resident representative, will develop a comprehensive care plan including measurable goals and interventions. Record review of the facility's, undated, policy titled Comprehensive Care Plan revealed The Comprehensive Care Plan will be developed within 7 days after completion of the comprehensive assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455690	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parks Health Center	111 Parks Village Dr. Odessa, TX 79765

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who needed respiratory care was provided with such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 (of 7 residents Resident #15 and Resident #29) reviewed for oxygen management. 1. The facility failed to ensure Resident #15 had an order for oxygen. 2. The facility failed to ensure Resident #29 had an order for oxygen and an Oxygen in Use sign on the doorway. These failures could place residents at risk of not receiving appropriate respiratory care. Findings include: 1. Record review of Resident #15's admission record, dated 01/15/2026, revealed a [AGE] year-old female with an original admission date to the facility of 07/26/2021 and re-admission on [DATE]. The admission record revealed Resident #15 had diagnoses which included congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), muscle weakness, emphysema (a lung disease that results from damage to the walls of the alveoli in your lungs), and shortness of breath. Record review of Resident #15's Quarterly MDS assessment, dated 12/31/2025, revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Section O revealed Oxygen Therapy was selected for use while a resident of the facility. Record review of Resident #15's Care Plan, dated 01/15/2026, revealed oxygen was not included in the Care Plan. Record review of Resident #15's order summary, dated 01/16/2026, revealed no orders for oxygen therapy. Observation on 01/13/2026 at 3:14 PM revealed Resident #15 was not in her room. The oxygen concentrator was set at 2.5 liters per minute. Observation and interview on 01/13/2026 at 4:21 PM revealed Resident #15 was in her room with the nasal canula on and the oxygen concentrator was on, set at 2.5 liters per minute. Resident #15 said she had to wear oxygen, or she had trouble breathing. Observation on 01/15/2026 at 8:17 AM revealed Resident #15 was asleep in a wheelchair with nasal canula on and oxygen concentrator on, set at 2.5 liters per minute. 2. Record review of Resident #29's admission record, dated 01/15/2026, revealed a [AGE] year-old female with an original admission date to the facility of 03/14/2023 and re-admission on [DATE]. The admission record revealed Resident #29 had diagnoses which included asthma (a chronic lung disease characterized by inflammation and narrowing of the airways, making it difficult to breathe), dyspnea (difficult or labored breathing), hypoxemia (low levels of oxygen in the blood), and shortness of breath. Record review of Resident #29's Initial MDS assessment, dated 01/02/2026, revealed the resident had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. Section O revealed Oxygen Therapy was selected for use while a resident of the facility. Record review of Resident #29's Care Plan, dated 01/15/2026, revealed oxygen was not included in the Care Plan. Record review of Resident #29's order summary, dated 01/16/2026, revealed no orders for oxygen therapy. Observation on 01/13/2026 at 9:30 AM revealed Resident #29 did not have an Oxygen in Use sign on the door. Observation on 01/13/2026 at 11:24 AM revealed Resident #29 was wearing a nasal canula and oxygen concentrator, set at 4.0 liters per minute. Observation on 01/15/2026 at 8:16 AM revealed Resident #29 did not have an Oxygen in Use sign on the door. Observation on 01/15/2026 at 2:08 PM revealed Resident #29 was in bed with the nasal canula and oxygen concentrator on, set at 4.0 liters per minute. During an interview with the DON on 01/15/2026 at 4:10 PM, the DON said oxygen had to be ordered by a physician or a physician's representative. The DON said her expectations were to have an Oxygen in Use sign on the door frame outside every room that had a resident using oxygen inside it. The DON said she and the ADON are responsible for assuring Oxygen in Use signs are placed correctly. The DON said if a resident was on oxygen without an order, the resident may not be getting enough oxygen causing shortness of breath and confusion due to inadequate oxygen levels in the blood. Record review of the facility's, undated, policy titled Resident Smoking and Oxygen Policy revealed Oxygen is administered only under physician orders or in emergencies per facility policy. Oxygen warning signs are posted when oxygen is in use.