STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675519	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larkspur	201 South John Redditt Drive 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 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 observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene for 1 of 8 residents reviewed for ADLs (Resident #2)The facility failed to ensure Resident #2 received timely incontinent care on 10/29/2025.This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs, which could result in poor care.Findings included:Record review of an admission Record for Resident #2 dated 10/29/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of cerebral infarction (stroke), type 2 diabetes, major depressive disorder (persistent sadness and loss of interest in doing things) and hypertension (high blood pressure).Record review of a Quarterly MDS Assessment for Resident #2 dated 9/1/2025 indicated she did not have any cognitive impairment with a BIMS score of 13. She was dependent on staff for toileting hygiene. She was always incontinent with urinary/bowel.Record review of a care plan for Resident #2 dated 3/10/2025 indicated she had bladder/bowel incontinence related to CVA. Interventions included to check the resident every two hours and assist with toileting as needed and clean peri-area with each incontinence episode. During an observation on 10/29/2025 at 9:26 AM, CNA C and CNA D were at the doorway of Resident #2 to perform incontinent care. CNA C and CNA D both donned (put on) a gown in the hallway and entered the resident's room. Both staff washed their hands and put on gloves. CNA C opened Resident #2's brief and pulled it down between her thighs and performed incontinent care. CNA D rolled the resident onto her right side. The linens were soaked in urine with a light-yellow ring on the flat sheet. The brief was saturated with urine and her gown was wet. Resident #2's buttocks were macerated (skin overly saturated with moisture). After the care was complete, CNA C applied a barrier cream to the resident's buttocks. CNA C placed a clean brief under the resident's buttocks and placed a clean gown on Resident #2. Both CNA C and CNA D placed clean linens on the bed and repositioned Resident #2 in the bed.During an interview on 10/29/2025 at 9:56 AM, CNA C said she was the transportation driver for the facility, but also was a CNA. She said she was notified the night of 10/28/2025 that she would need to work on the hall where Resident #2 resided. She said her shift started at 6 am that morning (10/29/2025). She said that the care that was observed with Resident #2 was her first round for the morning with the resident. She said Resident #2 was soaking wet from urine and Resident #2 informed her that she had not been changed since the night of 10/28/2025. She said the nurse aides were supposed to round and check the residents every 2 hours. She said that morning (10/29/2025) she was busy and had other things to do for residents on the hall that included giving a resident a shower and passed out the breakfast trays and picked them back up. She said Resident #2's bed was soaked, and should not have been that way if she was changed timely. She said residents could be at risk for skin breakdown if they were not changed timely.During an observation and interview on 10/29/2025 at 10:05 AM, Resident #2 was in her bed. She said the nursing staff checked on her once on the night of 10/28/2025, and changed her and it was after supper time. She said she was not checked and changed until a few minutes ago.During an interview on 10/29/2025 at 10:07 AM, CNA D said Resident #2's brief was saturated with urine and her gown was wet along with her linens on the bed. She said the nurse aides were supposed to round on the residents every 2 hours to make sure they were clean and dry. She said Resident #2 was a heavy wetter. She said residents could be at risk for skin breakdown if they were not checked and changed every 2 hours.During an interview on 10/29/2025 at 12:57 PM, the DON said incontinent care should be performed every 2 hours and as needed. She said she was not aware Resident #2 had not received care in a timely manner and the resident had not mentioned any concerns to her. She said residents could be at risk for skin issues if care was not done in a timely manner.During an interview on 10/29/2025 at 1:18 PM, the Administrator said incontinent care should be performed every 2 hours. He said he was not aware Resident #2 had not received care in a timely manner. He said he planned to in-service the nurse aides on rounding and incontinent care. He said there was a risk for skin issues if care was not done timely.Record review of the facility's policy titled Perineal Care Protocol dated September 2023 indicated, .To provide care of the external genitalia and anal area which promotes cleanliness and prevents infections.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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F 0761 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 observations, interviews, and record reviews, the facility failed to ensure drugs and biologicals were stored in locked compartments under proper temperature controls for 1 of 7 residents (Resident #3) reviewed for pharmacy services.The facility failed to ensure a tube of diclofenac sodium topical gel 1% (primary use for pain relief) was not in the room of Resident #3 on 10/28/2025.This failure could place residents at risk for adverse effects and reduced therapeutic effects of medication.Findings included:Record review of an admission Record for Resident #3 dated 10/28/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of benign neoplasm of cerebral meninges (non-cancer tumor in the brain), rheumatoid arthritis (chronic disorder that affects the joints), and chronic kidney disease (loss of kidney function).Record review of an admission MDS Assessment for Resident #3 dated 9/15/2025 indicated she had moderate cognitive impairment with a BIMS score of 11. During the 5-day look back period, the resident did not receive any scheduled pain medication regimen.Record review of a care plan for Resident #3 dated 10/20/2025 indicated she was on pain medication therapy with interventions to administer analgesic medications as ordered by physician.Record review of active physician orders for Resident #3 dated 10/28/2025 indicated there were no orders for diclofenac sodium topical gel 1%.During an observation and interview on 10/28/2025 at 9:20 AM, Resident #3 was in her room sitting in a recliner. She was alert to person, place, and time. She said she had been at the facility for a few days. A tube of diclofenac sodium topical gel 1% was on a desk in the room. She said she did not remember where she had received the topical gel.During an interview on 10/28/2025 at 9:28 AM, MA A said she had been employed at the facility for 10 years. She said there were not any residents in the facility that were able to self-administer medications, and the nursing staff gave the residents all their medications. She said she had given Resident #3 her medications that morning, but had not given her any topical gels.During an observation and interview on 10/28/2025 at 9:39 AM, MA A entered the room of Resident #3. She said the diclofenac was a medication out of the nurse's carts. She said she was not aware Resident #3 had a tube of diclofenac and would give it to the nurse.During an interview on 10/28/2025 at 2:39 PM, RN B said there were not any residents in the facility that were able to self-administer medications themselves. She said the nurses and medications administered the medications. She said MA A told her about the diclofenac sodium topical gel that was found in Resident #3's room. She said family would bring medications to the facility without notifying the nursing staff. She said all medications should be stored in the medication cart or in the medication room.During an interview on 10/29/2025 at 10:29 AM, the RP of Resident #3 said they were not aware the resident had a tube of diclofenac topical gel and had not taken any medications to the facility. The RP said the resident had been in rehab at a local hospital and may have gotten the prescription while she was a patient. The RP said Resident #3 did have a cream that was prescribed that could be applied to her knees and back, but did not know the name of the medication.During an interview on 10/29/2025 at 11:37 AM, the ADON said there were no residents in the facility that had been deemed safe to self-administer medications. She said medications should be stored in the medication carts or in the medication rooms. She said she was aware of the tube of diclofenac that was found in the room of Resident #3 on yesterday 10/28/2025. She said someone else could take the medications if they were left in the rooms or the resident could take too much of the medicine.During an interview on 10/29/2025 at 12:57 PM, the DON said medications should be stored in the medication room or in the medication cart. She was made aware of the diclofenac gel of Resident #3 that was found in her room. She said there could be a risk of improper administration. She said there were not any residents in the facility that were able to self-administer.During an interview on 10/29/2025 at 1:18 PM, the Administrator said medications should be stored in the medication room or in the medication cart. He said there were no residents in the facility who had been deemed safe to self-administer medications. He said if medications were not stored properly it could lead to getting the wrong dose of medicine, and it would not be administered as ordered by the physician. He said the nursing staff were responsible for ensuring medications were stored properly.Record review of the facility's policy titled Storage of Medications revised April 2007 indicated, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 2. The nursing staff shall be responsible for maintaining medication storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 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 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 1 of 7 residents (Resident #2) reviewed for infection control.The facility failed to ensure CNA C changed her gloves, washed or sanitized her hands, and placed clean items on dirty linens when providing care to Resident #2 on 10/29/2025.This failure could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:Record review of an admission Record for Resident #2 dated 10/29/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of cerebral infarction (stroke), type 2 diabetes, major depressive disorder (persistent sadness and loss of interest in doing things), and hypertension (high blood pressure).Record review of a Quarterly MDS Assessment for Resident #2 dated 9/1/2025 indicated she did not have any cognitive impairment with a BIMS score of 13. She was dependent on staff for toileting hygiene. She was always incontinent with urinary/bowel.Record review of a care plan for Resident #2 dated 3/10/2025 indicated she had bladder/bowel incontinence related to CVA. Interventions included to check the resident every two hours and assist with toileting as needed and clean peri-area with each incontinence episode.During an observation on 10/29/2025 at 9:26 AM, CNA C and CNA D were at the doorway of Resident #2 to perform incontinent care. There was a sign on the door that read Enhanced Barrier Precautions (staff were required to wear a gown and gloves when care was provided). CNA C and CNA D both donned (put on) a gown in the hallway and entered the resident's room. Both staff washed their hands and put on gloves. CNA C opened Resident #2's brief and pulled it down between her thighs. CNA C removed wipes from the package and wiped both inner thighs and her lower abdomen and placed the wipes in the trash. CNA C removed wipes from the package and wiped down the middle of her vagina from front to back. CNA D rolled the resident onto her right side. CNA C removed wipes from the package and wiped Resident #2's rectal area from front to back and placed the wipe in the trash and applied a barrier cream to the resident's buttocks. CNA C placed a clean brief under the resident's buttocks on the wet sheet and then rolled the linens under the resident. Resident #2 was rolled onto her back and the brief was secured. Resident #2 was rolled onto her left side, and the dirty brief and linens were removed from the bed by CNA D and placed in a plastic bag. Resident #2's gown was removed and placed in a plastic bag. CNA C removed her gloves and gown and placed them in the trash. CNA C washed her hands and exited the room to get clean linens. CNA C reentered the room with clean bed linens in a plastic bag. CNA C was wearing a gown and she washed her hands in the bathroom and applied gloves. CNA D removed her gloves and placed them in the trash and washed her hands. CNA D placed a clean gown on Resident #2. Both CNA C and CNA D placed clean linens on the bed and repositioned Resident #2 in the bed.During an interview on 10/29/2025 at 9:56 AM, CNA C said during the incontinent care provided to Resident #2, she should have changed her gloves when she changed task from dirty to clean. She said she should have sanitized or washed her hands after she removed gloves. She said she did not realize she never changed her gloves during the care. She said she was nervous because she was being observed. She said she should not have placed the clean brief on the dirty linens. She said there could be a risk for residents getting germs or cross contamination. She said she had a skills check-off not long ago on incontinent care.During an interview on 10/29/2025 at 11:37 AM, the ADON said hand hygiene should be performed before care, when hands were visibly soiled, during care, after barrier cream was applied, and when care was complete. She said staff could wash or use hand sanitizer to perform hand hygiene. She said gloves should be changed when tasks changed from dirty to clean and clean items should not be placed on dirty items. She said staff received training on skills on hire, yearly and as needed if concerns were noted. She said the nurse managers were all responsible for training staff on skills. She said if staff did not perform hand hygiene or follow infection control there could be a risk to the residents for infections or cross contamination.During an interview on 10/29/2025 at 12:57 PM, the DON said hand hygiene should be done before care, every time gloves were changed, when changing from dirty to clean, and at the end of care. She said hand hygiene included washing hands with soap and water or use of hand sanitizer. She said residents could be at risk for infections and she planned to in-service the staff.During an interview on 10/29/2025 at 1:18 PM, the Administrator said hand hygiene should be done before care, between dirty and clean tasks