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	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larkspur	201 S. 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3 of 6 residents (Residents #34, #66 and #71) and 2 of 7 staff (CNA A and CNA B) reviewed for infection control. 1. The facility failed to ensure CNA A followed EBP and proper infection control measures when providing direct care and handling soiled linens for Resident #66 on 6/08/2026. 2. The facility failed to ensure EBP was initiated and followed for Residents #34 and #66 on 6/08/2026 and 6/09/2026. 3. The facility failed to ensure CNA B followed EBP when providing direct care to Resident #71 on 6/09/2026. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings include: 1. Record review of Resident #66's facility face sheet, dated 6/10/2026, indicated Resident #66 was a [AGE] year-old male, readmitted [DATE], with diagnosis of atrial fibrillation (irregular heart rate). Record review of Resident #66's quarterly MDS assessment, dated 5/12/2026, revealed a BIMS of 07 that indicated Resident #66 had severely impaired cognition. He was dependent on staff for all ADLs, was always incontinent of bowel and bladder and had a pressure ulcer. Record review of Resident #66's comprehensive care plan, revision date 3/06/2026, indicated Resident #66 had a pressure ulcer to his right heel and required EBP for a chronic wound and to implement enhanced barrier precautions. Record review of Resident #66's order summary report, dated 6/10/2026, indicated Resident #66 did not have an order for EBP until 6/09/2026. During an observation on 6/08/2026 at 10:57 am Resident #66 was in bed and had dressings to his feet. There was no signage or PPE at the door indicating EBP. He could not answer questions about his wound or staff wearing PPE. During an observation on 6/08/2026 at 12:34 pm CNA A was in Resident #66's room providing incontinent care. She was not wearing any PPE and had placed soiled linens on the floor next to the bed. During an interview on 6/08/2026 at 12:41 pm CNA A said she did not know Resident #66 needed EBP because there was not a sign but he did have a wound so he should have EBP precautions in place. She said she should have worn a gown and gloves when giving care and placed the soiled linens in a bag not on the floor to prevent spreading infections. 2. Record review of Resident #34's facility face sheet, dated 6/10/2026, indicated Resident #34 was a [AGE] year-old male, readmitted [DATE], with diagnosis of infection of surgical site. Record review of Resident #34's electronic health record indicated Resident #34's MDS assessment was not yet due and had not been completed. Record review of Resident #34's initial care plan, dated 6/03/2026, indicated Resident #34 had a surgical wound and implement enhanced barrier precautions. Record review of Resident #34's order summary report, dated 6/10/2026, indicated Resident #34 had an order for treatment for a surgical wound dated 6/04/2026 and did not have an order for EBP until 6/09/2026. During an observation on 6/08/2026 at 11:56 am Resident #34 was in a wheelchair in his room and he had a dressing to his left leg amputation. There was no sign or PPE outside the room indicating need for EBP. During an observation and interview on 6/09/2026 at 8:44 am Resident #34 was in bed and had a wound vacuum dressing system in place to his left leg amputation. There were no signs or PPE at the door identifying need for EBP for his wound. He could (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not recall if the staff were wearing PPE or not. 3. Record review of Resident #71's facility face sheet, dated 6/10/2026, indicated Resident #71 was an [AGE] year-old female, admitted [DATE], with diagnosis of diabetes with chronic skin ulcer. Record review of Resident #71's quarterly MDS assessment, dated 4/22/2026, revealed a BIMS of 09 that indicated Resident #71 had moderately impaired cognition. She was dependent on staff for most ADLs, was always incontinent of bowel and bladder and had a diabetic foot ulcer. Record review of Resident #71's comprehensive care plan, revision date 4/22/2026, indicated Resident #71 had a diabetic ulcer to her left ankle, required EBP for a midline catheter and implement enhanced barrier precautions. Record review of Resident #71's order summary report, dated 6/10/2026, indicated Resident #71 had an order for EBP dated 5/31/2026. During an observation and interview on 6/08/2026 at 10:45 am Resident #71 had an EBP sign and PPE at her door. She was in bed with a midline catheter (a type of intravenous catheter) in her left upper arm and had a dressing to her left ankle. She could not recall if staff wore PPE when providing care. During an observation on 6/09/2026 at 8:58 am Resident #71 had an EBP sign at her door. CNA B and CNA C entered Resident #71's room to transfer her. CNA B provided direct care by positioning her and adjusting her linen with no PPE in place. Resident #66 was not ready to get up and they did not proceed with transferring her. During an interview on 6/09/2026 at 9:10 am CNA B said she was assigned to different halls and that EBP signs were used to identify residents that required PPE for care. She said she had overlooked that Resident #71 had an EBP sign and PPE at the door. She said she had been trained in EBP and for residents with wounds and tubes, a gown and gloves had to be worn to provide care. She said she forgot Resident #71 was on EBP when she went to get her up. She said Resident #34 did not have a sign posted outside his room. She said she had given care to Resident #34 without wearing PPE because she had forgotten he had a wound and PPE had to be worn. She said not following EBP could cause infections to spread. During an interview on 6/09/2026 at 9:41 am the Unit Manager said she was the unit manager for hall 600 and was responsible for the oversight of the EBP program. She said that she used the 24-hour report and order report to review and put EBP signs and PPE out for staff use. She said that Residents #34, #66 and #71 had wounds and there should have been EBP signs and PPE outside their rooms. She said the signs were the staff's way of knowing precautions were required. She said she was not sure how those residents were overlooked. She said soiled linen were never to be placed on the floor and all staff were trained on infection control for handling soiled linen. She said she helped train staff on EBP and infection control and staff were knowledgeable on the facility's infection control program. She said if staff did not follow EBP and proper linen handling infections could spread. During an interview on 6/09/2026 at 9:56 am the ADON said she was the infection prevention nurse and she and the unit managers oversaw that infection control measures were in place throughout the facility. She said she performed an audit a few times a month to help catch any missing precautions in place. She said that the posted signs and PPE were the staff's aid to recognize residents requiring EBP. She said that soiled linens were to be bagged and never placed on the floor to prevent cross contamination and spread of infections. During an interview on 6/10/2026 at 11:45 am the DON said the ADON was the infection prevention nurse and she along with the charge nurses and unit managers were responsible for initiating the EBP procedures. She said a resident with a wound or implanted devices should have an order for EBP, a sign and PPE outside their room. She said that the sign was the tool used for the staff to know EBP was required. She said that orders were reviewed weekly and Residents #66 and #34's EBP requirements were missed. She said that staff were trained in EBP and following the guidelines on hire and as needed. She said soiled linens were to be placed in a bag and never on the floor. She said that staff not following the facility's infection control program could lead to the spread of infections. During an interview on 6/10/2026 at 1:45 pm the Administrator said the DON and Infection Prevention nurse were responsible for the infection control program. He said that orders should be reviewed daily and if the residents needed EBP in place then it should be initiated and facility policy followed. He said all staff were trained on hire and at least quarterly on infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	control measures. He said that the staff should be following infection control measures and wear their PPE and appropriately handle soiled linen to prevent the spread of infections. He said he planned to re-inservice all staff and ensure measures were in place for daily monitoring for compliance. Record review of a facility policy titled Enhanced Barrier Precautions, dated 12/01/2025, indicated, .it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following:i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) 3. Implementation of Enhanced Barrier Precautions:a. Make gowns and gloves available immediately near or outside of the resident's room.4. High-contact resident care activities include:a. Dressingb. Bathingc. Transferringd. Providing hygienee. Changing linensf. Changing briefs or assisting with toiletingg. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline cathetersh. Wound care: any skin opening requiring a dressing. Record review of a facility policy titled Handling Soiled Linen, dated 12/30/2025, indicated, .It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. This policy pertains to soiled linen. 3. Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons.4. Used or soiled linen shall be collected at the bedside (or point of use, such as dining room) and placed in a linen bag or designated lined receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 1 resident (Resident #52) reviewed for enteral nutrition. The facility failed to ensure staff followed facility policy to label the formula label with date, time and initials of nurse when formula bag was started. This failure could affect residents by placing them at risk of dehydration and weight loss. Findings include: Record review of the face sheet, dated 6/09/26, reflected Resident #52 was a [AGE] year-old male who initially admitted to the facility on [DATE]. His diagnoses include severe protein-calorie malnutrition, paraplegia and dysphagia (difficulty swallowing). Record review of the nursing home MDS assessment, dated 3/13/26, reflected Resident #52 had a BIMS score of 09, which indicated moderate cognitive impairment. Resident #52 required total assistance from staff with ADLs. Resident #52 received 51% or more of total calories through tube feeding. Record review of Resident #52 comprehensive care plan revised on 5/28/2026 included resident was to have nothing by mouth due to medical condition and requires tube feeding due to swallowing problems. Record review of Resident #52 order summary report for June 2026 reflected nothing by mouth diet. Enternal feed order of Isosource 1.5 at 65 ml/hr via feeding tube with auto flushes of 50 ml every hour, start date 5/24/2026. During an observation on 6/08/2026 at 10:30 AM, noted that feeding bag of Isosource 1.5 hanging on feeding pump and infusing at 65 ml/hr via g-tube. Noted that label had no date, time or initials on the label. Approximately 30% of bag contained formula. During an interview on 6/10/2026 at 10:30 AM with LVN D, she stated she was the unit manager for Resident #52's unit and has been employed at the facility for 2 years. She stated nurses that hang a new bag of tube feeding should label the bag with date and time the bag is placed on the pump. She stated that feeding bags are safe to use for 48 hours after inserting tubing in feeding tube and labeling with date and time allow the charge nurse to monitor that the appropriate amount of feeding is being infused by the pump. She stated not labeling the feeding bag with the date, time and nurses initials could place residents at risk for receiving formula that has been opened over the recommended time of 48 hours and impede the nurses ability to ensure that the feeding is infusing at the proper rate. During an interview on 6/10/2026 at 10:45 AM with the Director of Nurses, she indicated the charge nurse was responsible for labeling all feeding bags with date, time and initials prior to administering the feeding. She stated labeling with date and time ensures that formula is not hanging longer than required and that the formula is infusing at the proper rate. She stated she expected the charge nurse to label all feeding bags according to the facility policy and if any unlabeled bags are noted by the charge nurse, the bag is to be removed and replaced with a new bag that is labeled appropriately.During an interview on 6/10/2026 at 11:30 AM with the Administrator, he stated the charge nurse is responsible for labeling any feeding bags administered to the residents. He stated the feeding bags should be labeled with date, time and initials of the nurse prior to administering the feeding. He said that proper labeling ensures the feeding is infusing over the appropriate time and not opened for longer than recommended. He stated that he expects the charge nurse to label all feeding bags according to facility policy. He said not labeling the feeding bags with the date, time and nurses initials could lead to feedings that are opened longer than recommended and the inability of the nurse to monitor feeding is infusing at the proper rate. Record review of a facility policy titled Enternal Feedings- Safety Precautions revised November 2018 indicated On the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order.

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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 3 of 3 days reviewed for 3 of 3 days reviewed (06/08/2026, 06/09/2026 and 06/10/2026) for nurse staffing posting. The facility failed to post the daily staffing information in a prominent place on 06/08/2026, 06/09/2026 and 06/10/2026.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 06/08/2026 at 11:01 AM, the daily staff posting was not in or around the front entrance lobby accessible to all visitors or residents. The daily staff posting was dated 06/08/2026 and located in a case on a wall in front of the Therapy department and down the hallway leading to 500/600 and 700/800 hallways. The posting was not visible to residents or visitors traveling toward the 100/200 and 300/400 hallways.During an observation on 06/09/2026 at 3:33 PM, the daily staff posting was not in or around the front entrance accessible to all visitors or residents. The daily staff posting was dated 06/08/2026 and located in a case on a wall in front of the Therapy department and down the hallway leading to 500/600 and 700/800 hallways. The posting was not visible to residents or visitors traveling toward the 100/200 and 300/400 hallways.During an observation on 06/10/2026 at 10:55 AM, the daily staff posting was not in or around the front entrance accessible to all visitors or residents. The daily staff posting was dated 06/08/2026 and located in a case on a wall in front of the Therapy department and down the hallway leading to 500/600 and 700/800 hallways. The posting was not visible to residents or visitors traveling toward the 100/200 and 300/400 hallways.During an interview on 06/10/2026 at 1:00 PM, the DON said ADON was responsible for staffing in the facility for the nurses and nurse aides. She said the daily staff posting was the responsibility of the ADON. She said the posting was on the wall near the Therapy department and also posted near the dining room. She said the location was previously at the receptionist desk at the main entrance, but they had moved it at some point in the past few years. During an interview on 06/10/2026 at 1:30 PM, the Administrator said the ADON and DON were responsible for putting out the daily staff posting. He said the posting would not be visible to visitors or residents if they turned to the left at the lobby and traveled to the 100/200 and 300/400 hallways. The Administrator said the purpose of the staff posting was so anyone would be able to see the census and how many staff were working that day. Record review of a facility policy titled Nurse Staffing Posting Information dated 12/30/2025 indicated, .It is the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff and visitors at any given time.