STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675565	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Village	2600 Parkview Dr Bedford, TX 76022

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for 1 of 2 residents (Resident #4) reviewed for abuse and neglect. The facility did not thoroughly investigate an incident in which Resident #4 made a grievance that a staff member pinched her. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm.The findings were: A record review of Resident #4's Nursing Home PPS MDS, dated [DATE], reflected the Resident #4 was an [AGE] year old female who was admitted to the facility on [DATE]. Resident #4 had an active diagnosis of Cerebral Infraction. Resident #4's had a BIMS score of 08, which indicated moderate cognitive impairment. A record review of Resident #4's Care Plan, dated 05/15/2026, reflected Resident #4 has two bruises to the left forearm. Goal to be free from skin tears and interventions included monitor/document location, size and treatment of bruise, keep skin clean and dry, inform staff of causative factors and measures to prevent skin issues, and encourage good nutrition in order to promote healthier skin. A record review of provider investigation report revealed on 05/15/2026 Resident #4 reported to the assistant director of nursing that she believed that a staff member had pinched her when they provided care. The provider investigation report revealed no alleged perpetrator was named, no documentation of who was contacted regarding alleged abuse allegation, no documentation of witness statements were provided. The provider investigation report reflected safe surveys were completed and abuse and neglect in-services were provided. Durning an interview on 05/29/26 at 9:25 a.m., the ADM revealed he was notified on Friday, 05/15/26 at 5:15 p.m., that there was an alleged allegation of abuse. The ADM stated that he had returned to the building on 05/15/2026 at 5:30 p.m. and interviewed Resident #4. The ADM stated that Resident #4 was unable to recall a specific date or time of incident only that it was Wednesday, Thursday or Friday night. The ADM stated Resident #4 was not able to provide a description of an alleged perpetrator. The ADM stated Resident #4 was unable to state what color scrubs the staff member wore. He stated that nurses wore burgundy and aides wore blue. The ADM stated Resident #4 showed him two marks on her arms and he asked Resident #4 was she pinched once or twice and Resident #4 responded once. The ADM stated he asked Resident #4 if she felt safe and Resident #4 replied yes she did. The ADM stated he asked Resident #4 if she was in pain and Resident #4 responded that she was not in pain. The ADM stated that he called the DON at or around 9:45 p.m. and instructed her to call staff who worked the night shift for 05/13/26, 05/14/26 and 05/15/26 to see if they were aware of what happened to Resident #4, start in-services and conduct safe surveys. During an interview on 05/29/2026 at 10:37 a.m., the DON revealed that she was notified by the ADM via phone that there was an alleged allegation of abuse. The DON stated that she had arrived at the facility the morning of Saturday, 05/16/26 and went to ensure Resident #4 felt safe and if she could provide any additional details. The DON stated Resident #4 revealed to her that she felt safe, but Resident #4 could not describe an alleged perpetrator, could not state what day it happened, could not provide if staff provided care or happened in bed. The DON stated she then conducted safe surveys of the residents to ensure everyone felt safe. The DON stated that there were no negative findings from safe surveys. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated she called staff that worked that Wednesday, Thursday and Friday night. She stated that no staff knew anything about Resident #4 bruises. The DON stated Resident #4 would often transfer herself to her bedside commode. The DON stated that the bedside commode had a lid and believed that it may have caused Resident #4 to have the two bruises. The DON stated Resident #4 required one person assist but often had to be reeducated to use call light or ask for assistance. Attempted phone interview with RN A on 05/29/2026 at 11:03 a.m., no answer and no returned call back prior to exit of the facility. Attempted phone interview with CNA B on 05/29/2026 at 11:06 a.m., no answer and no returned call back prior to exit. During an interview on 05/29/2026 at 11:35 a.m., CNA C revealed that she had worked the overnight shift and cared for Resident #4 on 05/14/26. CNA C stated that no staff contacted her about an alleged allegation of abuse. She stated she only found out through word of mouth when her nurse did not show up to work, and she asked why her nurse was not present and RN A informed her that she had been suspended pending investigation of alleged abuse. CNA C stated she received abuse and neglect in-service on 05/15/26 on the overnight shift. She stated that the in-service covered to handle patient carefully, never to be rough and if cause or see any skin concerns to report to the Administrator immediately. During an interview on 05/29/2026 at 12:45 p.m., Resident #4 revealed that she did not remember a staff member pinching her or that she had reported that to anyone. Resident #4 reported that staff had not been rough with her when they provided care. Resident #4 stated that she felt safe in the facility and with the staff that provided her care on all shifts. During an interview on 05/29/2026 at 1:26 p.m., RN B revealed that she was the overnight nurse that worked with Resident #4. She stated she had no knowledge of the allegation of abuse of Resident #4. She stated that the only allegation of abuse that she was suspended for was for a different resident. RN B stated that the DON nor the ADM called to ask her if she was aware of any skin concerns or aware of any bruising on Resident #4. Attempted phone interview with CNA D on 05/29/26 at 2:00 p.m., no answer and no returned call back prior to exit. During an interview on 05/29/26 at 2:15 p.m., the DON stated that a thorough investigation consisted of an interview with the resident, safe surveys, try to identify an alleged perpetrator, if an alleged perpetrator was found, suspend that individual pending investigation, complete in-service, report the allegation to the State, contact the police, notify family and physician, conduct assessments, monitor the resident, pain management if needed, determine outcome of investigation, if unconfirmed allow alleged perpetrator back, provide education to them prior to hitting the floor, and if founded, the alleged perpetrator is terminated. The DON stated she felt this was a thorough investigation. She stated they were unable to determine an alleged perpetrator. The DON stated that she was not aware why staff would state she did not talk to them as she did talk to everyone who she was able to get a hold of that worked on 05/13/26, 05/14/26 and 05/15/26. She stated that she was not sure of the names as she had only been at the facility one week at the time, but had a highlighted list of names of staff she physically talked to and provided those names to the ADM. She stated that she would ask the ADM where the list was because it should have been in the self-report. The DON stated that she was under the impression that the ADM typed up her findings and included them in the self-report. During an interview on 05/29/26 at 2:39 p.m., the ADM stated that as the Abuse Coordinator when there was an allegation he had to speak with the resident, ensure the resident felt safe, see if they were able to identify an alleged perpetrator, and if so contact that person and inform them they were suspended. He stated that if it was reported physical abuse, he'd have a nurse conduct head-to-toe assessment, pain management, contact police department, and notify family. The ADM stated that he would delegate someone to talk to staff and start in-services and safe surveys. He stated if a staff member was identified he would take their statement and report within the allotted time frame the alleged abuse. Then continue the investigation until complete and then decide based off information provided. He stated that dependent on the outcome if unfounded the alleged perpetrator would be able to return with education and if founded would be terminated. The ADM stated that he felt the investigation was thorough and complete. The ADM stated Resident #4 was unable to provide any details or description (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that would help them determine an alleged perpetrator, Resident #4 felt safe. He stated Resident #4 did not have any pain, in-services and safe surveys were completed. He stated that the DON had called staff who worked days prior to the alleged incident, but no one stated they knew anything. The ADM stated that he did not have any statements provided as they were conducted via phone. The ADM was unable to provide names of who were contacted. The ADM was not aware of who was not contacted. The ADM stated that the DON provided a list of staff she had contacted but was not able to locate the list. He did not believe there was a risk to the residents because he did not find anything concerning that would have led to abuse or neglect and there was no identifiable alleged perpetrator. A record review of safe surveys completed on 05/15/26, no negative findings. Record review of facility policy named Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating from Resident Rights and Abuse Prevention Policy and Procedure Manual 2001, revealedAll reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are retorted to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.10. The investigator consults daily with the administrator concerning the progress/findings of the investigation.11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator.Follow-up2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified.3. The follow-up investigation report will provide as much information as possible at the time of submission of the report.