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	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Village	2600 Parkview LN 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 good nutrition, grooming, and personal and oral hygiene for 2 of 6 residents (Residents #23 and #63) reviewed for ADL care.The facility failed to answer Resident #23 and Resident #63 call lights in a timely manner.This failure could place residents at risk for complications associated with delayed care such as skin breakdown and dignity issues.Findings included:Record review of Resident #23's face sheet reflected she was an [AGE] year-old female with an initial admission date to the facility of 02/19/2025. Her diagnosis included Parkinsonism (neurodegenerative disease), Muscle Wasting and Atrophy, and Muscle Weakness.Record review of Resident #23's Quarterly MDS, dated [DATE] reflected that she had a BIMS score of 13 (cognitively intact, normal thinking and memory). The resident required a wheelchair, required substantial/maximal assistance (Helper does more than half the effort) for transfers, showers and could not walk on her own. Resident #23 was always incontinent of bowel and bladder.Record review of Resident #23's Comprehensive Care Plan dated 01/25/2026 revealed that Focus: Resident #23 has an ADL self-Care performance deficit related to impaired balance, limited mobility, Parkinsonism. Goal: Resident #23 will maintain current level of function in ADLs through next review date. Interventions: Transfer: Resident requires Mechanical Lift with 2 staff assistance with transfers. The Resident required total assistance with transfers. The resident requires extensive assistance with, Toilet Use, Bed Mobility, Dressing and Bathing/Showering. Record review of Resident #63's face sheet she was an [AGE] year-old female with an initial admission date to the facility on [DATE]. Her diagnosis included: Fracture of eh Left Femur (Largest bone in the leg) Difficulty in Walking, Unsteadiness on the feet, and Muscle Weakness.Record Review of Resident #63's MDS dated [DATE] reflected that Resident #63's BIMS score was 15 (cognitively intact, normal thinking and memory). Resident #63 was totally dependent (helper does all of the effort) for toileting hygiene, Picking up an Object and Putting on/taking off footwear. She required Substantial/maximal assistance (Helper does more than half) for Lower Body Dressing, Showers/Bathing, Rolling Left to Right, Sit to Lying, Lying to Sitting on Side of Bed. Resident #63 was completely competent of bowel and bladder. Review of Resident #63's Comprehensive Care Plan dated 02/19/2026 reflected that Focus: Resident #23 has an ADL self-care performance deficit related to Impaired Balance, Limited Mobility, Limited ROM, Musculoskeletal impairment. Goal: Resident #63 will Improve current level of function in ADL's through the review date. Interventions: Encourage the resident to use bell to call for assistance. Focus: Resident #63 has an alteration in musculoskeletal status related to fracture of the left femur. Goal: Resident #63's wound will heal and progress without complications through the review date. Interventions: Anticipate and meet needs. Be sure call light is placed within reach and respond promptly to all requests for assistance. In an interview on 03/03/2026 at 1:08 p.m. Resident #63 stated that Call lights could take far too long to be answered. She stated that earlier that morning she had pressed the call light because she had to go to the bathroom, but no one came for over an hour and that she had ended up wetting herself. She stated that it was embarrassing and humiliating to wet herself and that she had (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	never wore adult briefs before but felt she had to wear them now because there had been several times that she had wet herself because call lights were not answered for over an hour. In an interview on 03/03/2026 at 1:33 p.m. Resident #23 had started to cry while stating that the staff often take over an hour to answer her call light. She stated that she didn't want to wait [for help] but that the staff made her wait. An observation on 03/03/2026 at 1:40 p.m. revealed that a call light was observed turning on over resident room [ROOM NUMBER], a CNA was observed entering the room and turning off he call light at 1:52 p.m. and the CNA was observed leaving the room and coming back with a nurse to attend to the resident.In an interview on 03/03/2026 at 4:20 p.m. with the husband of Resident #23 he revealed that he visited his wife everyday after work to care for his wife. He stated that his wife had been at the facility for over a year and that he had witnessed several times himself her call light going unanswered for over and hour. He stated that his wife had told him on several occasions her call light could go unanswered for 1-2 hours. He stated he had spoke to the Administrator a few times about the call lights but that he had seen no improvement in response times.In an interview on 03/05/2026 at 10:03 a.m. CNA K stated that if she is involved in giving showers sometimes it could take her up to 30 minutes to answer a call light. In an interview on 03/05/2026 at 10:24 a.m. CNA L revealed that some residents had complained to her that call lights could take 45 minutes to be answered. She stated that it would be beneficial to possibly have shower aides and then she might be able to attend to call lights more quickly. She stated that residents that have to wait too long to be changed could suffer skin degradation. In an interview on 03/05 at 10:39 a.m. CNA M stated that sometimes during shift changes it could take 45 minutes to answer a call light. She stated that some residents have complained to her that call lights take too long to be answered. She stated that residents might be embarrassed or have skin degradation if they are not helped quickly enough with call lights.In an interview on 03/05/2026 at 12:19 p.m. the ADM stated that he had been working with Resident #65 about their complaints of CNA's being rushed and call light response times by meeting with the resident on a regular basis. He stated that it was important for a residents' psycho-social health and to avoid possible skin degradation for call lights to be answered as quickly as possible and residents to receive help in no more than 15 minutes.A record review of the facility Grievance Files found three Grievances written by Residents #105, #106, and Resident #107, written on 2/19/2026, 2/17/2026, and 02/04/2026 respectively. All three grievances described the wait for call lights to be answered as a very long timeIn an interview on 03/05/2026 at 1:14 p.m. with Resident #105 on the telephone, Resident #105 revealed that she had pressed her call light around 2:00 p.m. and no one had come for over and hour, she stated that she eventually had her son go to the nurses station and ask for someone to come to her room as she needed to have her adult brief changed. She stated that it took nearly 2 hours to get any help from the staff, and it had happened more than once while she had been at the facility.Attempts to reach Residents #106 and #107 via phone on 03/05/2026 at 1:28 p.m. and 03/05/2026 at 1:38 p.m. the surveyor was able to leave messages but the Residents did not call the surveyor back before the end of the survey.In an interview on 03/05/2026 at 3:47 p.m. the DON revealed that her expectation for call lights to be responded too were as quick as possible, CNA's had been instructed to answer call lights in any area of the facility, not just their assigned area. She further revealed that 15 minutes was the upper limit for a call light to be answered, and if call lights were not answered in a timely manner, it could cause incidents/falls or psych-social harm or lead to skin degradation.In an interview on 3/19/26 at 9:22 AM with the ADM and DON the ADM stated that they had assigned some additional duties to the ADON's and that one of those duties were for staffing coordinator. he stated there had not been any more complaints/grievances involving call light response times. The DON remarked that that staff had been instructed to answer call light wherever/whenever they see one, whether it is in their assigned area or someone else's. She stated that all the nurses and staff had been in serviced on Resident Rights, Call Light Response time and Customer Service on 10/1/25, 12/9/25 and on 3/4/26. She stated that the nurses and herself were monitoring call light response time by going into resident rooms on all (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	three shifts and recording the time it takes to be answered, she stated that they would continue to do those exercise for the next 3 months.In an interview on 3/19/26 at 10:30 AM Resident #63 stated that the call light issue was only that one time, but they did improve their response time, and she felt that it was because they were both getting used to each other's schedules. she stated that she had been very satisfied with her stay at the facility and that CNA's and that she had had no other issues at all while she had stayed at the facility. She denied that she had suffered any mental anguish or physical harm as a result of her incident.In an interview on 3/19/26 at 10:48 AM Resident #23 appeared to be in a much better mood. she stated that the call light response times had been much better. [NAME] stated that she was doing fine, and that she had no current complaints.In an interview on 3/20/26 at 10:00 AM CNA K stated that she had received training in answering call lights, resident rights and customer service. She stated that they have had similar training before and she stated that the facility had made one of the ADON's in charge of staffing. She stated that there was also a new rule that if you see a call light go and answer it no matter where you are assigned. She stated that no call light should go unanswered for more than 5 minutes.In an interview on 3/20/26 at 10:09 AM CNA L stated that she had been at this facility for 13 years. She stated that she had received training for call light response time and Resident Rights and customer service recently and remembered having those in-services many times. She stated that staff had been instructed to answer any call light they see no matter where they are assigned to. She stated the ADON was now in charge of staffing, and that no call light should take more than 5 minutes to be answered.In an interview on 3/20/26 at 10:39 AM CNA M stated that the ADON was now in charge of staffing and that she seemed pretty good at it. She stated that all CNA's and Nurses had been instructed to answer a call light, it doesn't matter which hall you are assigned too. She stated that that has helped a lot and she thinks call lights are answered very quickly now. she stated that she received in-services for Res Rights, Call Lights, and Customer serviceReview of a facility Policy titled Answering the Call Light dated September 2022, the policy stated: Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs.1. Answer the resident call system immediately. a. If the resident needs assistance, indicate the approximate time it will take for you to respond.c. If the residents request is something you can fulfill, complete the task within 5 minutes if possible.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for 2 of 6 residents (Residents #25 and Resident #7) completed and accurate records. The facility failed to ensure Resident #7 and Resident # 25 had either a Full Code or a Do Not Resuscitate status listed in the electronic medical record making it unclear as to what the code status was. This failure placed residents at risk of not having their preferences and wishes honored in an emergency.Findings included: Record review of Resident # 25's face sheet, dated [DATE], reflected an [AGE] year-old female admitted [DATE]. Her diagnoses included acute myocardial infarction (heart attack caused by a decreased or complete cessation of blood flow to a portion of the myocardium) bipolar disorder (a chronic mental health condition characterized by extreme and long lasting shifts in mood, energy and activity levels, alternating between high and low states), Parkinson's (a progressive , degenerative neurological disorder that impairs motor function), dementia (a decline in mental ability such as memory loss and reasoning problems), and chronic kidney disease (a long term condition where kidneys cannot filter blood effectively). The face sheet indicated that she was Full Code (a designation indicating that if a patients heart stops, lifesaving interventions will be used) and a DNR (a document directing healthcare providers not to perform cardiopulmonary resuscitation if heart or breathing stops). Record review of current physician orders dated [DATE], reflected an order for Full Code with a start date of [DATE] and a DNR order with a start date of [DATE]. Record review of the OOH-DNR (a document that instructs paramedics or nursing home staff not to perform lifesaving measures. reflected it was executed on [DATE] and was completed with all necessary signatures. Record review of Resident # 25's admission MDS, dated [DATE], revealed a BIMS (Brief Interview of Mental Status) score of 3 which indicated severe cognitive impairment. In an interview on [DATE] at 2:55 p.m. with RN C stated Resident #25 was full code and then stated the EHR indicated Resident # 25 was also a DNR. She checked the actual DNR document and stated that she was a DNR. She was not sure why Resident # 25 had a full code and a DNR status listed on the face sheet. She stated the risk to the residents would be that staff would start CPR and the resident might be a DNR. Record review of Resident #7's face sheet dated [DATE], reflected a [AGE] year-old male admitted [DATE]. His diagnoses included unspecified dementia (a decline in mental ability such as memory loss and reasoning problems), anxiety (a fear of dread, apprehension and tension), depression (a mental illness causing persistent sadness) hypertension (high blood pressure) and Parkinson's (a progressive degenerative neurological disorder that impairs motor function) . The face sheet indicated Resident #7 was Full Code and a DNR. Record review of current physician orders dated [DATE], reflected an order for Full Code with a start date of [DATE] and a DNR order with a start date of [DATE]. Review of the OOH-DNR reflected it was executed on [DATE] and was completed with all necessary signatures. Record review of Resident # 7's Quarterly MDS, dated [DATE], revealed a BIMS score of 9 which indicated moderate impairment.During an interview on [DATE] at 3:09 p.m. with RN D stated that she was not sure what the code status was for Resident #7 because both Full Code and DNR were listed in the EHR. She stated in an actual emergency she needed to know quickly what it was. She stated the risk to the resident was life and death. During an interview on [DATE] at 3: 56 p.m., the social worker stated she spoke with the family and/or resident right after the admission to find out about the code status. She stated she assisted with getting the paperwork completed and scanned into the medical record. She notified the ADON who entered in the order for the code status. She stated the risk to the resident was their wishes might not be followed correctly. During an interview on [DATE] at 4:05 p.m., ADON E stated she had not looked at the code status orders and was not aware until today ([DATE]) that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was an issue. She stated the nurse cannot delay CPR if the nurse cannot find the OOH-DNR. She stated the risk was that staff would not know how to render care. During an interview on [DATE] at 6:12 p.m., Resident #7 stated he did not want CPR and had a document in his records indicating that choice. In an interview on [DATE] at 6:00 p.m., the DON stated when someone was admitted , the nurse and the ADON looked at the orders and the resident ws automatically a full code if there was not an order, if they have a DNR, that order will be added. She stated the company recently changed from EMR system to another and that might have something to do with why someone would have a full code and a DNR order. She stated they were currently doing a full audit to update the system and educate all the nurses. She stated the risk to the residents was that it could go against their rights. Record review of the Advanced Directive policy dated [DATE] reflected in, If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. The residents wishes are communicated to the residents' direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **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 was offered a therapeutic diet when there was a nutritional problem and the health care provider ordered a therapeutic diet for one (Resident #65) of three residents reviewed for therapeutic diets. The facility failed to ensure Resident #65 was offered alternative menu items for a therapeutic diet when she did not like the meal and received ordered Boost (supplement shake) instead of Glucerna (supplement shake for diabetes). This failure placed residents at risk of weight loss, receiving the wrong supplement, and not having choices of alternate menu items.Findings included: Review of Resident #65's quarterly MDS Assessment, dated 02/06/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident had a BIMs score of 8. The resident's cognition was moderately impaired. The resident had diagnoses including cancer, non-Alzheimer's dementia, stroke, malnutrition, and adult failure to thrive. The resident was on a mechanically altered diet. Review of Resident #65's Comprehensive Care Plan reflected:02/01/26 Resident had an unplanned/unexpected weight loss related to failure to thrive.Facility Interventions included: Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss.12/16/25 Resident had a potential nutritional problem related to diet restrictions.Facility interventions included: Provide, serve diet as ordered. Monitor intake and record every meal. Review of Resident #65's Order Summary Report reflected:03/01/26 Pureed diet texture and regular/thin liquids.02/21/26 Boost three times a day for supplement. Review of Resident #65's Weights reflected:12/24/25155.4 pounds01/19/26133.6 pounds02/10/26126.6 pounds03/03/26124.0 pounds Review of Resident #65's Progress Notes reflected:Effective Date: 02/01/26 9:59 PM Nutrition/Dietary Note Weight evaluation: Weight down 19.6% x 30 days and 16.3% x 90 days. Receiving 237 milliliters Glucerna at night, however, weight loss continues. Oral intake appears to have decreased from 50-75% to no 0-25% on puree diet. Receiving health shakes two times a day.Recommend:1. Evaluate for starting appetite stimulant to assist with intake; meeting estimated nutritional needs.2. Continue wound healing supplementation.3. Continue current diet regimen.4. Continue Glucerna and health shakes.Goals: adequate intake, weight stability, intact skin. RD to continue to monitor weight changes, skin breakdown, intake.Author: RD IEffective Date: 02/14/26 4:46 PM Type: Nutrition/Dietary NoteWeight evaluation / skin evaluation. CBW 126.6#, BMI 21.7. Noted significant weight loss of 18.3% x 30 days and 22.7% x 90 days. Weight loss continues. Oral intake poor at 0-50%. Receiving health shakes twice a day for an additional 440 kcal and 14 grams protein. Receiving Glucerna at night to provide an additional 180 kcal and 12 grams protein/day. Medications reviewed; albumin 2.3, glucose 73.Recommend:1. Stop Glucerna.2. Start Boost VHC 120 milliliters three times daily between meals to provide an additional 800 kcal/33 g protein/day.3. 3. Continue health shakes twice a day to provide an additional 400 kcal and 12 grams protein/day.4. Goals: adequate intake, intact skin, weight stability. RD to continue to monitor weight changes, skin breakdown, intake.Author: RD IEffective Date: 02/17/26 8:41 AM Type: Nurses NotesLeft message for son to call back to discuss the med ordered for appetite to get consent, Mirtazapine 7.5 milligrams dailyAuthor: ADON EEffective Date: 03/03/26 at 2:58 PM Type: Nutrition/Dietary NoteNote Text: Physician here and notified of resident weight loss of 7.5% since January. Stat albumin ordered. Resident frequently refusing weekly weights and lab. Will continue to attempt. Dietary Manager spoke with resident today regarding diet alternatives. Resident ate 50% of her meal and was offered fruit and a health shake which she consumed.Author: DONEffective Date: 03/03/26 3:20 PM Type: Nutrition/Dietary NoteNotified resident's son of weight loss and poor appetite. He said he has been aware of her weight loss since she admitted . He said they have discussed a feeding tube and that option is a hard no.Author: DONEffective Date: 03/03/26 3:27 PM Type: Nurses NotesPhysician made rounds and new orders were received. Give Mirtazapine 7.5 milligrams by mouth every night for (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appetite.Author: ADON E An observation and interview on 03/03/26 at 12:10 PM with Resident #65 revealed she was sitting upright in bed. She said she was waiting on staff to help her sit up and help her eat. CNA F entered the resident's room and said she was going to feed Resident #65. CNA F positioned the resident and removed the lid of the tray. It was a puree diet. The resident ate a few bites of the food. CNA F said if the resident did not like the food on her tray, she could ask if the resident wanted something else to eat. CNA F showed the resident the food ticket and said she could only pick off food from the food ticket. The resident said she liked bread but did not want pureed bread. CNA F said there were no other alternatives for the resident to eat. The resident said she did not want any of the food on the ticket. CNA F said if the resident did not like the food then she could lose weight. An interview on 03/03/36 at 12:39 PM with ADON G revealed the facility did offer an always available menu. ADON G said if the resident did not eat the food, then she could lose weight. ADON G asked Resident #65 what she wanted to eat and she said she wanted chicken salad. ADON G said she would make sure the staff brought chicken salad to the resident. An interview on 03/04/26 at 12:00 PM with Resident #65 revealed she did not like breakfast. She said staff told her they would bring her something different, but they never did. An interview on 03/04/26 at 12:10 PM with CNA F revealed she fed Resident #65 breakfast and she ate 50% of the meal. CNA F said she did not offer her anything else to eat. An interview on 03/04/36 at 12:45 PM with MA H revealed she administered Glucerna on 03/04/26 (supplement shake for diabetic residents) after the lunch meal to Resident #65. MA B said she drank more than half of it. MA B said she gave the resident Glucerna and not Boost as ordered. MA B did not give a reason for giving the resident Glucerna. An interview on 03/04/26 at 1:15 PM with RD I and RD J regarding Resident #65 revealed the facility had been monitoring the resident's weight loss on a monthly basis. They said the resident needed to drink Boost instead of Glucerna because Glucerna was not for limited intake. They said they addressed her weight loss multiple times over months. They said they did not know why staff did not offer her an alternative menu. They said the resident started on mirtazapine (appetite stimulant) on 03/03/26. An interview on 03/04/26 at 1:40 PM with Dietary Manager revealed she spoke to Resident #65 on admission regarding her food preferences. The Dietary Manager said the resident wanted to eat regular food, not puree food. The Dietary Manager said the resident was able to order off the always available menu. An interview on 03/04/36 at 1:55 PM with the DON revealed the resident was not being treated for diabetes. She said she did not know why staff did not offer Resident #65 an alternative meal because she said they usually did. The DON (new to the facility) said she found out about Resident #65's weight loss on 03/03/26 and the Registered Dietician was contacted for review. The DON said she did not know why mirtazapine was not ordered before 03/03/26. The DON said ADON E was in charge of monitoring resident's weight loss. The DON said if a resident was not offered alternative food choices they could become malnourished and dehydrated. The DON said she did not know why MA B gave the resident Glucerna instead of Boost. An interview on 03/04/36 at 2:55 PM with ADON E revealed she was in charge of monitoring weight loss in residents. She said Resident #65 did not have consistent weights and she had to notify the Registered Dietician for a weight loss of more than 3%. ADON E said the resident was offered health shakes and Boost. ADON E said she knew the resident had been refusing meals and did not know how much she ate. ADON E said she did not know why the mirtazapine was not ordered but knew it had been previously discussed An interview on 03/04/26 at 4:00 PM with the DON revealed for weight monitoring, the Registered Dietician would monitor monthly. She said the mirtazapine was not ordered because it was overlooked by ADON E. The DON said Resident #65 was supposed to receive high calorie Boost and not Glucerna. She said that even though the Surveyor intervened and identified the issue with the resident's weight loss; the DON was going through the weights and said she would have found it. The DON said ADON E was responsible for ensuring interventions for weight loss were effective.An interview on 03/04/26 at 5:45 PM with Physician revealed Resident #65's weight loss was identified in December 2025 and January 2026, and interventions were put in place. He said he had discussed getting the resident a feeding tube, but the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family said no. He said the mirtazapine was not previously ordered because the resident was very sensitive to medication.A Record Review on 03/19/26 at 11:48 AM of a document titled Order Listing Report Revealed that 23 residents currently had orders for supplements at the facility. Residents #77, #98, #73, #23, #3, and #45 were selected from this list for observations and interviews.A record Review on 03/19/26 at 11:50 AM of Resident #65's Wound Care notes dated 11/4/25 and 03/03/26 respectively, found that the resident had admitted to the facility with several wounds, the wounds had healed slowly over time and had decreased in size, but ultimately the overall prognosis for the resident was poor.In an interview on 3/19/26 at 1:17 PM the DON stated that the facility had a new system for tracking dietary/supplement recommendations/orders. She stated that ADON E was now the nurse in charge of the weight program and a new binder had been developed in which ADON E would sign that recommendations had been communicated to the Physician. She stated that the binder would be in DON's office and that she was monitoring that recommendations/orders were being properly processed by checking the Electronic Health Record System on a daily basis.In an interview on 3/19/26 at 3:43 PM with Resident # 65's son, the son revealed that his mother had had orders from the hospital for a pureed diet because of some swallowing issues and so he insisted she stay on a pureed diet. He stated that he visited his mother twice everyday and that she was always offered alternatives to eat and was offered a variety of liquid supplement shakes but she was very stubborn and she often refused to eat, and she hated Glucerna the most. He stated that he had been made aware of her weight loss by the facility and had many conversations with the nurses and the Physician. He stated that the Physician had recommended a G-Tube but he had flat out refused that option as he knew that was against his mother's wishes. He stated that is mother had decent care at the facility and he had no complaints about her care or treatment.In an interview on 3/19/26 at 4:42 PM the Physician stated that Resident #65 had been very selective about what she would eat and often refused to eat despite being offered alternatives. He stated that receiving Glucerna as opposed to Boost would have made no difference in her weight at all. He stated that she also would refuse to take medications to increase her appetite. He stated that he had had several conversations with Resident #65's son about her weight loss and interventions that they could try including inserting a G-Tube that the son refused to do that. He stated that at that point no interventions would have made a difference as Resident #65 did not want supplements or medications, she had many contributing comorbidities. All of these factors contributed to her wounds healing slowly. Resident #65's attitude and prognosis did not lend to a good outcome.Review of the facility policy, Alternative Foods, not dated, reflected: PolicyAppropriate alternate foods will be prepared and offered at each meal for food preferences.

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	03/20/2026

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

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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 reviews 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 one (Resident #104) of five residents, reviewed for infection control. 1. The facility failed to ensure LVN K performed hand hygiene and changed his gloves after treating one wound and moving on to another wound on Resident #104. This failure placed residents at risk for healthcare associated cross contamination and infections.Findings included: Review of Resident #104's Annual MDS Assessment, dated 02/25/26, reflected the resident was an [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were not impaired. His diagnoses included cancer, heart failure, diabetes, cellulitis of the right leg and left leg. The resident had infection of the foot and open lesions other than ulcers. Review of Resident #104's Care Plans, dated 03/03/26, reflected:Actual impairment to skin integrity. Trauma on right lower leg and trauma on right food, 2nd toe. Facility interventions: follow facility protocols for treatment of injury. Review of Resident #104's Order Summary Report, dated 02/24/26, reflected:Cleanse trauma on right lower leg with normal saline, pat dry, apply triple antibiotic ointment, leave open to air, apply every evening shift and as needed.Cleanse trauma on right 2nd toe with normal saline, pat dry, apply triple antibiotic ointment, leave open to air, apply every evening shift as needed. An observation on 03/04/26 at 9:35 AM with WCN revealed he was preparing to provide wound care to Resident #104. Resident #104 was seated in his wheelchair. LVN K cleaned the wound on the right lower leg and applied the treatment. LVN K did not change gloves or perform hand hygiene. LVN K then cleaned the wound on the toe of the right food and applied the treatment. An interview on 03/04/26 at 9:45 AM with the WCN revealed he said it was ok to use the same gloves to treat different wounds. He said he did not know he was supposed to change his gloves and perform hand hygiene between wounds. He said failure to complete hand hygiene and change gloves could lead to infection. An interview on 03/05/26 at 3:47 PM with the DON revealed staff were supposed to change gloves and perform hand hygiene between wounds. She said failure to perform hand hygiene and gloves between wounds could lead to infection. Record review of the facility policy, Handwashing/Hand Hygiene, revised August 2015, reflected: .7. Use an alcohol-based hand rub.or soap.and water for.k. After handling used dressings.

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	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum the required committee members for three (October 2025, November 2025 and December 2025 of four meetings reviewed for QAPI.1. The facility did not ensure the Infection Preventionist attended the December 2025 meeting.2. The facility did not ensure meeting occurred monthly as per their policy and did not conduct meetings for January 2026 and February 2026.These failures could place residents at risk for quality deficiencies being unidentified, infections, no appropriate plans of action developed and implemented, and no appropriate guidance developed.Findings include:Record Review of the facility's QAPI Committee sign in sheets indicated the Infection Preventionist was absent from the March 2026 meeting. Further review found that the facility was not able to produce Committee sign in sheets for the months of January 2026 and February 2026.In an interview on 03/05/2026 at 12:19 p.m. the ADM stated that the facility's policy is to conduct QAPI meeting on a monthly basis and that the meetings were where they developed new interventions and evaluated the effectiveness of prior interventions. He stated that without the meetings the facility might not be able to effectively keep residents from harm or improve resident lives to a higher standard.In an interview on 03/05/2026 at 3:47 p.m. the DON related that she had recently attended a QAPI meeting on 03/04/2026, she stated that only herself and the Medical Director and the ADM were there. She started that the facility needed all members there to be able to get the information for efficient interventions. Insufficient meetings could impeded the development of setting interventions and reviewing those interventions to see if they are effective.Record review of the facility's policy titled Quality Assurance and Performance Improvement Program, . revised on 02/2020 indicated, Authority (1) The owner and/or governing board (body) of our facility is ultimately responsible for the QAPI Program . 3. The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan .