STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675777	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Place	1321 Park Bayou Dr Houston, TX 77077

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (CR #1) of three residents reviewed for accidents, hazards, and supervision.The facility failed to ensure CNA G did not leave CR #1 unattended on the commode while she went and called LVN M to come and assess CR #1's foley because he was pulling on the foley and had asked CNA G to remove the foley, and he was bleeding from the penial area.This failure increased the risk of injury, hospitalization, and death for residents.Findings included:Record review of CR #1's face sheet dated [DATE] revealed, a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. CR #1's diagnoses included benign prostatic hyperplasia (enlargement of the prostate gland), restlessness (inability to remain calm), agitation (behavior like pacing or pulling), atherosclerotic heart disease (artery walls of the heart thicken and become less flexible), repeated falls, and indwelling urinary catheter (a flexible tube inserted through the urethra into the bladder to continuously drain urine).Record review of CR #1's 5-day MDS assessment dated [DATE] revealed a BIMS of 14, indicating intact cognition. Further review revealed Resident #1 need moderate assistance with toileting, and moderate assist/independence with transfer.Record review of Resident #1's 48-hour care plan dated [DATE] revealed Resident #1 was at a minimized risk for fall. Further review also revealed the resident had a self-care deficit in personal care. Intervention: task segmentation, cue as needed, encourage independence as much as able, allow time to complete task, set up for self-care.Record review of CR#1 physician date [DATE] revealed Aspirin low-strength 81 mg tablet, delayed release 1 time daily was held for 3days on [DATE] for hematuria. Record review of Resident #1's OT therapy ended on [DATE] revealed the goal was to use the grab bars with a standard commode with supervision for safety.Record review of Resident #1's care plan dated [DATE] revealed the resident was a fall risk related to hypotension and history of fall. Intervention: ambulate with wheelchair or walker, call light and personal items within easy reach and bed in low position. Further review revealed CR#1 was a DNR.Record review of Resident #1's CNA service plan dated [DATE] revealed Resident #1 needed one person assist with ADL and toileting. Further review revealed Resident #1 needed one person/independent with transfer.Record review of Resident #1's fall assessment on [DATE] revealed Resident #1's score was 25, which indicated a high risk for fall.Record review of the OT assessment on [DATE] revealed Resident #1 was at partial/moderate assistance with commode transfer with supervision. Record review of CR #1 progress note dated [DATE] at 3:02 p.m. revealed CR #1 returned from the hospital and CR #1 denied pain, foley was intact and patent and draining mild yellow with some tinged blood in the foley bag. Plan was to continue monitoring for hematuria, pain and difficulty urination. It also revealed that CR #1 was confused. Then at 7:30 p.m., CR #1 was lying in bed with responsive with no complaints of pain or distress and the foley catheter was intact and drained tinged color urine output.Record review of Resident #1's incident report dated [DATE] revealed Resident #1 was found on the floor close to the room entrance door, and LVN M stated he was gasping for air and 911 was called. Then Resident #1 (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stopped breathing before 911 arrived, and he was pronounced dead at 10:24 PM.During an interview on [DATE] at 1:08 p.m., LVN M said she was the nurse on duty when CR #1 fell. LVN M said CR #1 could go to the restroom by himself, and if he needed assistance, he would put on his call light. LVN M said CNA G came and told her CR #1 was sitting on the commode in his restroom, pulling on the foley, bleeding, and had discontinued the foley bag. She said she was in another resident room when the aide came and told her, and it was around 10:00 p.m. LVN M said when she was going towards the red hall from the blue hall, CNA G was running back towards her and said the resident fell. She said she found Resident #1 lying on his back on the floor close to his room entrance door, and the resident stretched out his right hand, and she held the resident's hand. She said the resident was gasping for air, and she told CNA G to go and ask the other nurse to call 911, and she placed a pillow under his head. She said it was less than a minute and CR #1 stopped breathing. She said she assessed the resident, and he was not bleeding from another part of his body except from the penial area from pulling on the foley. LVN M said she would given CR #1 oxygen but he stopped breathing less than a minute when she reached him and she could not do CPR because he was a DNR. She did not respond when asked if it was safe for CNA G to have left agitated Resident #1 alone in the restroom, and she did not respond. LVN M said 911 came within 5 minutes. She said the resident was pronounced dead around 10:24 p.m.During an interview on [DATE] at 2:47 p.m., DOR said CR #1 needed moderate assistance with transferring from bed to W/C, W/C to bed, and toileting. She said she notified the nursing staff during the morning meeting if the nursing staff asked whether CR #1 needed assistance with transfer. She said she did not remember if the nursing staff asked the level of assistance the residents needed with transfer and ADL care. DOR said CR #1 did not meet his transfer and toileting goal before he was discharged to the hospital on [DATE]. DOR said OT reassessed CR #1 on [DATE] when he came back from the hospital, and CR #1 still needed moderate assist with one staff for transfer and toileting.During a telephone interview on [DATE] at 2:31 p.m., CNA G said CR #1 pulled the emergency light in the restroom around 10:00 p.m., and when she responded to the call light, CR #1 was sitting on the toilet and had transferred himself from the bed to his wheelchair and then to the toilet. CNA G said CR #1 was pulling on the foley French after he had disconnected the foley bag from French. She said the resident's hands were bloody from pulling on the foley, and CR #1 was asking her to remove the foley, and she told him she could not remove the foley and he had to wait so she could go call LVN M. CNA G said Resident #1 was agitated and kept asking her to remove the foley. She said CR #1's room was at the back of the red hall and LVN M was in another hall. CNA G said the red light was blinking above the front of CR #1's room door and at all the nursing stations, but the light did not beep. She said even if you were in the hallway, you would not see the blinking call light because the resident's room was at the end of the hall to the right. She said she had to leave CR #1 in the restroom because even if she shouted for help, nobody would hear her. She said LVN M was in a resident room in the blue hall when she went and told her CR #1 was pulling on his foley and he wanted the foley taken out and when she and returned to CR #1's room, she found CR #1 lying on his back on the floor close to the entrance door to his room. She said she went back and told the nurse that Resident #1 was on the floor. She said she then ran to another hall to call another CNA to come and help, and the nurse was almost to Resident #1's room when they came back. CNA G said LVN M told her to go and tell the other nurse to call 911. CNA G said when she came back to where CR #1 was lying on the floor, he was not breathing, and 911 came.During an interview on [DATE] at 2:56 p.m., RN C said CR #1 could transfer himself depending on how he was feeling. RN C said the staff would go and talk to him, then determine if he needed help and the staff would assist with the transfer or toileting. She said Resident #1 could also call for help when he needed help. RN C said Resident #1 could fall and may hurt himself if he was left alone in the bathroom while he was agitated and asking for the foley to be taken off.During an interview on [DATE] at 4:32 p.m., the DON said CR #1's CNA ADL plan read CR #1 needed one staff assist for transfer/independent. The DON said this meant the resident could transfer by himself, or the staff could assist him. She said the staff would (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ask CR #1 if he needed help with ADL care and the staff would assist CR #1 when he needed help with transfer and toileting, or CR #1 would put on his call light for the staff to come and assist him. The DON said she had two nurses and three CNAs on the day Resident #1 fell and passed away. The DON said CNA G did the right thing when she left Resident #1 on the commode and went to call the nurse. She said CNA G was not aware the resident would transfer himself after CNA G told him she was going to call the nurse. The DON said the emergency call light lit up in front of the resident's room and on the computer at all the nursing stations. She said the call light dinged very faintly at the nursing station. The DON said if there was a nurse or CNA at the nursing station, they would have seen the call light. She said they did not have any plans in place to prevent leaving a resident who was agitated alone on the commode to go and call a nurse. She said the state frowned on cell phones and headsets.During an interview on [DATE] at 5:45 p.m., RN C said she was the nurse that admitted CR #1 when he came back from the hospital on [DATE], and she initiated the 48-hour care plan and entered CR #1 needed one staff assistant with transfer. When the surveyor told her the transfer read assist x1/independent, RN C said she did not realize she checked independently. She said that goes back to the aides checking on Resident #1 to see if he needed assistance with transfer or any ADL care, if he needed assistance then the staff would help CR #1 or when he pulled call light for help then the CNA who responded to the call light would assist him.During an interview on [DATE] at 5:50 p.m., with the DON, the Administrator, and RN C, the Administrator said it was not possible for an aide to stay with a resident who was on the commode all the time because at any given time there would be about four residents in the bathroom. When she was asked about a resident that was agitated, pulling on the foley, asking for it to be removed, and bleeding, she said CNA G had to call LVN M, which was why she left the resident unattended. The Administrator said the shift was staffed with two nurses and three aides based on the residents in the building. She said they had 35 residents in the building during the incident. She said the emergency light beeped at the nursing station, but it was a low beep. She said the facility was working on a plan to prevent leaving a resident alone when a resident was in the restroom.During an interview on [DATE] at 3:00 p.m., CNA B said aides were not supposed to leave Resident #1 when he was agitated, and if it was an emergency, she would use her cell phone to call LVN M, pull the emergency light, or yell for help. CNA B said Resident #1 could fall and hurt himself.During an interview on [DATE] at 3:24 p.m., CNA D said she would call for LVN M on her phone, and if she did not have her phone, she would yell to get attention because you were not supposed to leave Resident #1 alone in the restroom when he was agitated. CNA D said CNA G should not l have left CR #1 alone because he was already pulling the foley and could try to get up from the toilet by himself and fall.During an observation of the call light on [DATE] at 5:22 p.m. with the DON, it was revealed the emergency call light in Resident #1's bathroom did light up above the resident's entrance door and on all computers at the nursing stations, but it did not make a noise. The surveyor requested facility policy for supervision and competency for CNA G and LVN M who worked with Resident #1 on the day of the incident.During record review and interview on [DATE] at 5:40 p.m., the DON said the facility resident emergency bathroom call light on the day of the incident showed the emergency restroom call light was pulled at 9:57 p.m. and was canceled at 9:57p.m. The DON said it was the resident that pulled and canceled the call. It also revealed the call light was pulled again at 9:58 p.m. and was canceled at 10:00 p.m. The DON said that was when CNA G responded to CR #1's emergency call in the bathroom, and the only way to cancel the call was from the restroom. She said it took 2 minutes before it was canceled. She said that was when CNA G canceled the call light and told CR #1 she was going to call the nurse.During interview on [DATE] at 9:54 a.m., the DON said the aides and nurses would not be able to see the emergency call at the nurses station if they were not at the station. she did not respond to how CNA could have reached LVN M without leaving CR #1 alone in the toilet. She said CNA G told her she calmed down CR #1 and told him she was going to call LVN M to come and assess his foley and to put the call light on if he needed help before she left to call LVN M.During an interview on [DATE] at 2:25 p.m., CR #1 Family member said she did not know CR #1 had (continued on next page)

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