STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675962	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Rehabilitation and Healthcare Center	501 N Medford Dr Lufkin, TX 75901

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 the residents' environment remains as free of accident hazards as possible for 2 of 16 residents reviewed for quality of care. (Resident #3 and Resident #6) The facility failed to remove worn and damaged mechanical lift slings from service for Resident's #3 and #6 on 2/26/26. The facility failed to ensure CNA B locked the brakes for safety during a transfer of Resident #3 on 2/26/26. These failures could result in a loss of quality of life due to injuries.Findings include: 1.Record review of a facility face sheet dated 2/26/26 for Resident #3 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of intervertebral disc degeneration, lumbar region with discogenic back pain only (Intervertebral disc degeneration in the lumbar region can lead to discogenic back pain and lower extremity pain due to the breakdown of spinal discs, which may compress nerves and cause discomfort).Record review of Resident #3 clinical record revealed the admission MDS assessment had not been completed . Record review of a baseline care plan dated 2/24/26 for Resident #3 indicated he had an ADL self-care performance deficit and had an intervention requiring staff participation for transfers. During an observation on 2/26/26 at 9:30 a.m., CNA A and CNA B were observed transferring Resident #3 from bed to wheelchair using a mechanical lift. A lift sling was observed in room on overbed table for use with transfer. The sling loops were observed to be faded in color. CNA B said she did not think they were faded in color. When asked what color the sling loops were , she said, well, yes, they are faded from when they were new. She went and got another lift sling to use for transfer. During the transfer, after securing the loops on the hooks and prior to lifting resident from the bed, CNA B did not lock the brakes on the mechanical lift. CNA B also did not lock brakes before lowering Resident #3 onto his wheelchair. During an interview on 2/26/26 at 1:35 pm CNA B said she did not lock the brakes when transferring Resident #3, she said she must have forgotten. She said the lift could tip over and residents could get hurt if the brakes were not locked. She said she would check the lift slings for wear and tear, rips, tears, and faded colors before use. She said if unsafe slings were used, they could break, and the resident could fall. During an interview on 2/26/26 at 10:10 am ADON said she expected her staff to follow proper policy and procedures when using the mechanical lift, which included locking the brakes for resident safety. She said a resident could fall and be injured if brakes were not locked. 2.Record review of a facility face sheet dated 2/26/26 for Resident #6 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of cerebral palsy (a neurological condition that affects muscle movement and development). Record review of a quarterly MDS assessment dated [DATE] for Resident #6 indicated a BIMS score of 00, which indicated she was severely cognitively impaired. She was dependent with transfers. Record review of a comprehensive care plan dated 4/19/22 for Resident #6 indicated she had an ADL self-care performance deficit and required assistance of 2 staff members for transfers using a mechanical lift. During an (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Rehabilitation and Healthcare Center	501 N Medford Dr Lufkin, TX 75901

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 2/26/26 at 10:00 am Resident #6 was observed sitting in a wheelchair in the common area near nurse's station. She was observed to have a mechanical lift sling underneath her with loops that were observed to be fraying. During an interview on 2/26/26 at 1:20 pm Laundry Director said lift slings were laundered with no bleach and air dried. She said if she noticed a sling with discoloration or fading, rips, or tears, she would show it to the DON so it could be removed if needed. She said residents could get hurt if a sling broke during a transfer. During an interview on 2/26/26 at 1:40 pm Resource RN said she expected her staff to follow policy and procedures when using the mechanical lift to transfer residents using the mechanical lift. She said if brakes were not locked when lifting or lowering resident, the lift could go off balance and fall, possibly injuring the resident. She said if an unsafe sling was used, it could break causing resident injury. She said they would be providing in-services and education regarding the use of mechanical lift and inspection of lift slings. Record review of a Clinical Competency Review dated 1/6/26 for CNA B indicated she had been demonstrated proficiency using the hydraulic lift on 1/6/26. Record review of a facility policy titled Mechanical Lift undated read: .Ensure that the mechanical lift equipment is in good working condition, and safety checks performed as per manufacturer recommendations. and .Inspect the sling for any damage or wear before use. and .Position the mechanical lift, ensuring that the base is stable and locked.

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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 observation, interview 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 6 residents (Resident #3) and of 1 of 4 staff (CNA A) reviewed for infection control. The facility failed to ensure CNA A washed or sanitized their hands between glove change during incontinent care provided to Resident #3 on 2/26/2026. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings include: Record review of a facility face sheet dated 2/26/26 for Resident #3 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of intervertebral disc degeneration, lumbar region with discogenic back pain only (Intervertebral disc degeneration in the lumbar region can lead to discogenic back pain and lower extremity pain due to the breakdown of spinal discs, which may compress nerves and cause discomfort). Record review of Resident #3 clinical record revealed the admission MDS assessment had not been completed. Record review of a baseline care plan dated 2/24/26 for Resident #3 indicated he had an ADL self-care performance deficit and had an intervention requiring staff assistance for toileting. During an observation on 2/26/26 at 9:30 am CNA A was observed providing incontinent care on Resident #3. After cleaning feces from rectal area, she was observed removing the glove from her right hand and without washing or sanitizing her hands, she then put a clean glove on her right hand. She did not change the glove on her left. She then proceeded to put clean brief on Resident #3 and assisted with transferring him from bed to chair. During an interview on 2/26/26 at 1:05 pm CNA A said she did not sanitize her hands during peri care and said she did only [NAME] the one glove on her right hand after cleaning rectal area. She said when she went in there, she did not know she would need to perform incontinent care on him and was not really prepared. She said it could put residents at risk for infections if proper handwashing or sanitizing was not done. During an interview on 2/26/26 at 10:10 am ADON said she expected her staff to perform hand hygiene when providing incontinent care for residents. She said if proper hand hygiene was not followed, residents could be at increased risk for infections. During an interview on 2/26/26 at 1:40 pm Resource RN said she expected her staff to follow policy and procedures when providing incontinent care to residents and to always perform hand hygiene, especially when going from dirty to clean. She said residents could get an infection if hand hygiene was not performed. She said, going forward, staff would receive education and more checkoffs to ensure compliance. Record review of a facility policy titled Hand Hygiene dated 10/2022 read: .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: .h. Before moving from a contaminated body site to a clean body site during resident care; .m. After removing gloves.