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	01/07/2026

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 kitchen reviewed for pest control. The facility failed to ensure the kitchen remained free from roaches. On 1/05/2026 roaches were observed crawling on the wall behind the bags of cereal in the dry pantry area, and crawling on the floor in the main kitchen prep and cooking area. This failure could place residents at risk for reduced quality of life and poor sanitary environment.Findings included: During the initial tour of the kitchen dry pantry area on 1/05/2026 at 9:00 AM, a live roach was seen crawling up the wall behind the cereal, upon moving the bags of cereal dried roach excrement was observed on the wall. During the initial tour of the kitchen main cooking and preparation area on 1/05/2026 at 9:05 AM, a live roach was observed crawling on the floor under the stove and oven area. During an interview on 1/5/2026 at 9:00am the DM said the food delivery company had delivered a box of potatoes that contained roaches and that was where the roaches originated from. She said they had the roach problem for about a month. She said now they opened all boxes of vegetables outside to make sure they do not bring any additional roaches into the kitchen. During an interview on 1/5/2026 at 9:10am [NAME] A said the roaches had been a problem for about a month. She said the food delivery company had delivered some potatoes in a cardboard box that had roaches in it. During an interview on 01/06/2026 at 10:19 AM the DM said she verbally notified the Administrator sometime within the last week that there was still a roach problem in the kitchen. She said that roaches could possibly get in the food and make the residents sick. She said going forward her expectations were for food to be stored and served under sanitary conditions. During an interview on 01/07/2026 at 9:31 AM [NAME] B said she had seen roaches in the kitchen since about November 2025. Said she had reported the roaches to the DM. She said when the exterminator sprayed the roaches would get worse. She said since they changed exterminators the roaches had been better, but she had still seen them. She said roaches could get in the residents' food and make them sick. During an interview on 01/07/2026 at 9:36 AM the Dietary Aide said he had seen roaches in the kitchen for about 2 weeks. He said he had reported the roaches to the DM. He said the exterminator had been out and sprayed for the roaches right before 12/25/2025. He said roaches could carry diseases and they could get in the residents‘ food and make them sick. During an interview on 01/07/2026 at 9:39 AM the Dishwasher said he had seen roaches in kitchen since about November 2025 when the new exterminator started coming and spraying. He said roaches carry diseases and are a menace to the residents and could possibly make the residents sick. During an interview on 01/07/2026 at 9:45 AM the Administrator said he knew about the roach problem in the kitchen. He said in November 2025 the facility changed pest control companies in an effort to address the roach problem. He said he was aware that there were still roaches in the kitchen but felt like the facility was addressing the problem appropriately. He said the roaches could possibly make the residents sick. During an interview on 01/07/2026 at 10:25 AM the Maintenance Director said he was aware there was a pest problem in the kitchen. He said they contracted a new exterminator company in November 2025. He said they came and sprayed the facility the first time on 11/17/25 and then told him they would come back and spray again 12/1/25. He said they did not return on 12/1/25 to spray the second time. He said the next time they sprayed the kitchen was on (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/19/25. Record review of the facility's Quality Team Tracking Form dated 11/13/2025 indicated a problem area of Roach Activity. Interventions included: .8. Pest control vendor will provide twice every two weeks for a month then monthly. 9. Dietary/Designee will monitor for any new or worst sightings and pest control vendor will be notified same day for treatment. Record review of contracted pest control company invoice dated 11/13/2025 indicated live roaches found in the cafeteria and were treated. Record review of contracted pest control company invoice dated 11/17/2025 indicated live roaches found in the cafeteria and were treated. Record review of contracted pest control company invoice dated 12/19/2025 indicated live roaches found in the cafeteria and were treated. Record review of the facility's Pest Control Policy/Procedure undated indicated: Policy: It is the policy of this facility to provide an environment free of pests. Procedures: 1. The facility will have a Pest Control vendor contract that provides treatment of the environment for pests. 2. The pest control visits will occur at least monthly. 3. It will allow for additional visits when a problem is detected. 4. Monitoring of the environment will be done by the facility's staff. 5. Pest Control problems will be reported promptly.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 4 residents (Resident #3) reviewed for care plans.The facility failed to ensure Resident #3's comprehensive care plan revision date 11/10/2025 reflected problems, goals or interventions for congestive heart failure and vascular insufficiency including application of compression stockings daily and their removalThis failure could place residents at risk of not receiving appropriate care to meet their current needs. The findings included: Record review of a face sheet dated 01/05/26 indicated Resident #3 was a [AGE] year-old male admitted on [DATE]. His diagnoses included congestive heart failure (inability of the heart to pump effectively), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).Record review of a Quarterly MDS assessment dated [DATE] for Resident #3 indicated he had intact cognition with a BIMS score of 15. Section I - Active diagnosis indicated Resident #3 had heart failure and venous insufficiency-chronic peripheral.Record Review of a comprehensive care plan on 01/06/2026 revision date 11/10/2025 indicated no problem area related to congestive heart failure, no goals for congestive heart failure and no interventions for congestive heart failure, such as application of compression stockings, monitoring edema and administration of diuretic therapy.During a record review on 01/05/2026 at 3:21 PM physician order dated 08/29/2025 indicated: apply light to moderate compression stockings above the knees every morning and remove at bedtime, one time a day and remove per schedule. During an interview and observation on 01/06/2026 at 09:15 am Resident # 3 said he had not had any compression stockings applied to his lower legs by staff in months. He said he did not have any compression stockings in his room. He said it was too difficult for him to apply the compression stockings by himself, so he had not thought about it too much. Resident #3 said he was not aware that the staff were to put his compression stockings on every day and that the medical doctor had ordered for them to be applied every morning and be removed every evening by nursing staff. Resident #3 was observed at 09:15 am sitting in his wheelchair in his room with no compression stockings on. His legs appear dark pink and have edema. During an interview on 01/07/2026 at 11:30 AM the MDS Coordinator said she was responsible for revising and updating the care plans. The MDS Coordinator said she was new to the MDS process for the facility. The MDS Coordinator said the risk to the residents could include all members of the IDT not knowing what was going on with the residents or any needed change in interventions not being addressed as an example Resident #3 not having his compression stockings applied and coordination with staff to ensure the application occurred each morning and what needed to be monitored due to his congestion heart failure and venous insufficiency, in example: skin condition, increased swelling. The MDS Coordinator said she would update the care plan to address Resident #3's problem of congestive heart failure. During an interview on 01/07/2026 at 10:00 AM, the DON said the MDS Coordinator was responsible for updating and revising the comprehensive care plans. She said other staff would update them as well, whenever needed. She said she would get communications during the morning meetings if there was something about a resident that needed to be updated on the care plan. She said the MDS Coordinator also does reviews quarterly and after each MDS assessment such as a change of condition. She said if interventions for congestive heart failure including application of compression stockings were not included in the care plan , staff may not know resident needs and changes in care provided. She said that if a resident was refusing an ordered intervention, it should be included on the comprehensive care plan.During an interview on 01/07/2026 at 10:30 am the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator said he was aware that Resident #3 had a problem with his care plan and interventions for congestive heart failure. He said MDS Coordinator was responsible for updating and revising the comprehensive care plans and the care plan would be updated. He said if interventions were not included in the care plan, staff may not know about resident needs and changes in care provided. Record review of a facility policy titled Comprehensive Care Plan Revision dated 01/2022 reflectedPolicy Statement:It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.Procedure:1. Within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care.2.The baseline care plan will include the minimum healthcare information necessary to properly care for a resident including, but not limited to:a) Initial goals based on admission orders,b) Physician orders,c) Dietary orders,d) Therapy services,e) Social services; andf) PASARR recommendations, if applicable.3. The facility team will provide a written summary of the baseline care plan to the residents and their representatives that includes the initial goals of the resident, a summary of medications and dietary instructions, and any services and treatments to be administered. This summary will be in a language and conveyed in a manner the residents and/or their representatives can understand. This summary will be provided by the time of the completion of the comprehensive care plan.s. The resident has the right to refuse or discontinue treatment. In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify.Page 1 of 2-Title: Comprehensive Person-Centered Care Planning care or service declined, the associated risks, IDT's effort to educate the residents and resident representative and any alternate means to address risk.6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments.7. The facility IDT includes, but is not limited to the following professionals:A. Registered Nurse with responsibility for the resident.B. Nurse Aide with responsibility for the resident; .An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.Policy Interpretation and ImplementationI. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.2. The Interdisciplinary Team documents in the CAT (Care Area Triggers) summary sheet and/or records in the clinical record: a. The residents' status in triggered CAT areas; b. The team's rationale for deciding whether to proceed with care planning; and c. Evidence that the team considered the development of care planning interventions for all CAT's triggered by the MDS.3.Each resident's Comprehensive Care Plan has been designed to: a. Incorporate identified problem areas, b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d .Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care; f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; and g. Enhance the optimal functioning of the resident by focusing on a rehabilitative program.4. The resident's Comprehensive Care Plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MOS).5. Care plans are revised as changes in the residents' condition dictate. Care plans are reviewed at least quarterly and any significant change in status.6. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate documentation will be entered into the resident's clinical records in accordance with established policies.Record Review of a facility policy dated 10/2007Resident Rights-Refusals:POLICY:It is the policy of this facility to honor a resident's request not to receive medical treatment as prescribed by his/her physician, as well as care routines outlined on the resident's assessment and plan of care.PROCEDURES:1. The resident is not forced to accept any medical treatment and may refuse specific treatment even though it is prescribed by a physician.2. An IDT team member will assess the reasons for the resident's refusal of treatment and attempt to educate the resident/family as to the consequences of such refusal and update plan of care as needed.3. Should the resident refuse to accept treatment, the refusal must be entered into the resident's medical record. The attending physician will be notified of such refusal and orders updated and followed as warranted. Care plan will be updated related to refusal of treatment/care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan, meet professional standards of quality for 1 of 4 residents reviewed for following physician orders. (Resident #3) The facility did not ensure that Resident #3's compression stockings were applied every morning as ordered by the physician on 01/05/2026 and 01/06/2026. This failure could place the residents at risk for increasing edema or worsening of vascular insufficiency (inability to return blood back into circulation). Findings included:Record review of a face sheet dated 01/05/26 indicated Resident #3 was a [AGE] year-old male admitted on [DATE]. His diagnoses included congestive heart failure (inability of the heart to pump effectively), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During observations on 01/05/2026 Resident #3 was observed sitting in his wheelchair at 10:00 am in common area, 12:30 pm in hallway D and 3:00 pm in the dining area during resident council meeting with no compression stockings on his lower extremities. During a record review on 01/05/2026 at 3:21 PM physician order dated 08/29/2025 indicated: apply light to moderate compression stockings above the knees every morning and remove at bedtime, one time a day and remove per schedule. During an interview and observation on 01/06/2026 at 9:15 am Resident # 3 said he had not had any compression stockings applied to his lower legs by staff in months. He said he did not have any compression stockings in his room. He said it was too difficult for him to apply the compression stockings by himself, so he had not thought about it too much. Resident #3 said he was not aware that the staff were to put his compression stockings on every day and that the medical doctor had ordered for them to be applied every morning and be removed every evening by nursing staff. Resident #3 was observed at 9:15 am sitting in his wheelchair in his room with no compression stockings on. His legs appear dark pink and have edema. During an observation on 01/06/2026 at 2:00 pm Resident #3 was participating in an activity in the dining room. He had compression stockings on both lower legs. During a record review of a Medication and Treatment Administration Summary for January 2026 indicated on 01/05/2026 LVN D indicated she had completed application of compression stockings as ordered. During a record review of a Medication and Treatment Administration Summary January 2026 indicated on 01/06/2026 LVN E indicated she had completed application of compression stockings as ordered.Record Review of a comprehensive care plan on 01/06/2026 revision date 11/10/2025 indicated no problem area related to congestive heart failure, no goals for congestive heart failure and no interventions for congestive heart failure such as, application of compression stockings, monitoring edema and administration of diuretic therapy. During an interview on 01/06/2026 at 9:45 am LVN B said she had signed the Medication/treatment administration record on Resident #3's application of compression stockings, but she had not put them on him. LVN B said that she should not have signed the task off without completing it as ordered by the medical doctor. LVN said that not following MD orders could result in swelling and decreased circulation of Resident #3's lower extremities. LVN B said that she would obtain compression stockings from the supply room and complete application for Resident #3. During an interview of 01/06/2026 at 10:15 am the DON said that orders should not be signed off by the nursing staff if not completed. She said that not completing MD orders could result in negative outcomes for the residents. The DON said she had been informed that Resident #3 was refusing application of his compression stockings but there was no documentation in the progress notes and refusals were not included in Resident #3's current care plan. During an interview on 01/07/2026 at 10:30 am the Administrator said orders should not be signed off by the nursing staff if not completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He said that not completing MD orders could result in negative outcomes for the residents. Record Review of a facility Policy dated 3/2023 Pharmacy Services/Nursing ServicesSubject: Physician OrdersPharmacy Services/ Nursing Services Physician Orders POLICY:It is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. It is the policy of this facility to accurately transcribe and implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.PROCEDURES:1.No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses.2.All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used.3.admission orders are reviewed with the physician upon admission based on the discharge instructions from the discharging facility and are transcribed accordingly. There is a double check system to verify accuracy of order transcription. Verify resident name on hospital paperwork matches the resident's name.4.Verbal orders for drugs, treatments, procedures shall be received only by licensed nurses, psychiatric technicians, pharmacists, nurse practitioners, physicians, physicians' assistants (from their supervising physician only), and certified respiratory therapists when the orders relate specifically to respiratory care.5.Verbal orders must be recorded immediately in the residents' chart by the person receiving the order and must include the date and time of the order.6.Medication, treatment or related orders are transcribed in the Medication Administration Record or the Treatment Administration Record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents requiring respiratory care are provided care, consistent with professional standards of practices for 2 of 6 residents reviewed for respiratory care (Residents #11 and #44). The facility failed to ensure the external filters of Resident #11's and #44's oxygen concentrators were free of dust build up on 1/7/26. These failures could place residents who require respiratory care at risk for respiratory infections, breathing in dust and allergens, decreased effectiveness of oxygen concentrators, and exacerbation of respiratory distress.Findings included: Record review of a facility face sheet dated 1/5/26 for Resident #11 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnosis of dementia and chronic respiratory failure with hypoxia (occurs when the lungs cannot effectively exchange oxygen and carbon dioxide, leading to low oxygen levels in the blood). Record review of a comprehensive MDS dated [DATE] for Resident #11 indicated a BIMS score of 00, which indicated severe cognitive impairment. She was dependent for all ADLs. She received oxygen therapy while a resident in the facility. Record review of a physician's order summary report dated 1/5/26 for Resident #11 indicated she had the following physician's order dated 5/30/23: .O2 (oxygen) at 2-4L/min per NC (nasal cannula) . Record review of a comprehensive care plan dated 9/24/25 for Resident #11 indicated she received oxygen therapy related to chronic respiratory failure with hypoxia. Record review of a facility face sheet dated 1/5/26 for Resident #44 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (uncontrolled blood sugar) and COPD (chronic obstructive pulmonary disease - a progressive lung disease characterized by obstructed airflow and breathing difficulties). Record review of a Quarterly MDS assessment dated [DATE] for Resident #44 indicated a BIMS score of 13, which indicated she was cognitively intact. She was dependent for most ADLs. She received oxygen therapy while a resident in the facility. Record review of a physician's order summary report dated 1/5/26 for Resident #44 indicated the following physician order dated 3/25/25: .O2 (oxygen) at 2-5L/min continuously per NC (nasal cannula) . Record review of a comprehensive care plan dated 4/15/22 for Resident #44 indicated she received oxygen therapy related to COPD and chronic respiratory failure. During an observation on 01/05/2026 at 10:04 am Resident #11 was observed lying in bed sleeping. She did not awaken to voice. She was wearing oxygen via nasal cannula. Oxygen concentrator outer filter was observed to be dirty with a thick buildup of dust. During an observation on 01/05/2026 at 10:21 am Resident #44 was observed lying in bed. She did not speak when spoken to. She was wearing oxygen via nasal cannula. Oxygen concentrator outer filter was observed to be dirty, with a buildup of thick dust and hair. During an interview on 01/06/2026 at 9:30 AM DON said administrative staff are supposed to check concentrator filters during department head rounds because the nurses are too busy to check them. She said angel rounds are supposed to do be done every day. During an interview on 01/07/2026 at 9:15 am DON said their staff had just been pulled short with having to work the weekends so often lately that the concentrator filters just got missed. She said they would do a better job going forward and she would ensure staff did a better job of keeping them clean. She said there was really no risk for the filters having dust buildup and that the concentrator would just quit working if it got clogged. During an interview on 01/07/2026 at 9:25 am Administrator said he would be making the ADON responsible going forward to monitor and ensure the concentrator filters were cleaned. He said he expected his staff to provide the best quality of care that they could and if the concentrator filters were allowed to have dust buildup, the residents were not going to be getting the best quality of care. Record review of a facility policy titled Oxygen Administration dated 3/2025 read: .Nursing staff is responsible for cleaning filters .