STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115005	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Nursing Facility	1865 Bold Springs Road Monroe, GA 30655

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 0656 Level of Harm - 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 staff interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to implement the care plan for one of 58 sampled residents (R) (R14). Actual harm was identified to have occurred on 05/07/2026, when R14 sustained a laceration to the right side of the forehead, right ankle sprain, and abdominal wall contusion from a fall from his bed that occurred when staff provided ADL care with one-person assistance when the resident required two-person assistance.Findings include:Review of the facility's policy titled Comprehensive Care Plan, dated October 2025, revealed the Policy section included, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The Policy Explanation and Compliance Guidelines section included . 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.Review of the admission Record for R14 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, multiple sclerosis, muscle wasting and atrophy, and acute and chronic respiratory failure with hypoxia. Review of the Significant Change Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/05/2026, revealed that section GG (Functional Abilities and Goals) documented that the resident had bilateral upper and lower extremity impairment and was dependent for toileting hygiene, personal hygiene, and rolling left and right on the bed. The MDS stated that dependent meant that the assistance of two or more helpers was required to complete the activity. Review of the care plan for R14 revealed a Focus, dated 03/31/2023 and revised 03/28/2024, of the resident had an ADL self-care performance deficit secondary to a diagnosis of multiple sclerosis. Interventions/Tasks included, but were not limited to, the resident requires assistance by two staff to turn and reposition in bed, date initiated 03/31/2023 and revised on 02/11/2026. Review of the Progress Notes for R14 revealed an entry dated 05/07/2026 at 11:00 PM and titled Incident Note that documented the nurse was called to the patient's room via a CNA. The resident was lying on the floor next to his bed on his back with CNA BB standing over him and applying pressure to his bleeding forehead. The CNA reported that as she was changing the resident's linen after an incontinent episode, he rolled off the bed and hit his head on the side of the bed. A head-to-toe assessment was completed, vital signs were taken, the Nurse Practitioner was notified, and the resident was sent to the emergency room (ER) for evaluation. Review of the ER record for R14, dated 05/07/2026, revealed the reason for the visit was a fall. The diagnoses were: fall from bed, laceration of the skin of the forehead, sprain and strain of the right ankle, contusion of the abdominal wall, and injury of the head. The record documented that a laceration repair was completed. In an interview on 06/10/2026 at 10:05 AM, Licensed Practical Nurse (LPN) stated that R14's care plan indicated the resident required two persons for bed mobility. She stated the resident had a fall from the bed on 05/07/2026, when CNA BB was changing him unassisted, and sustained a laceration (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Actual harm Residents Affected - Few	on his forehead. She stated R14 was transported to the emergency room and received sutures for the head laceration. In an interview on 06/10/2026 at 10:05 AM, CNA BB stated that on 05/07/2026, she provided care and changed R14's bed linen by herself. She further stated R14 fell from the bed and sustained a forehead laceration during the care. She stated she was unaware that the resident required two-person assistance with bed mobility. She stated she had received training on following the resident care plans. In an interview on 06/10/2026 at 11:50 AM, the Director of Nursing (DON) stated CNA BB provided care to R14 unassisted and did not follow the care plan for a two-person assist. She further stated that care was not provided according to the assessed needs of the resident and the care plan, and her expectation was for the care plan to be followed. Cross-Reference F689

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F 0689 Level of Harm - 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 staff interviews and record review, the facility failed to ensure that Activities of Daily Living (ADL) care was provided by the appropriate number of staff, to prevent accidents, for one of four residents (R) (R14) sampled for ADL care. Actual harm was identified to have occurred on 05/07/2026, when R14 sustained a laceration to the right side of the forehead, right ankle sprain, and abdominal wall contusion from a fall from his bed that occurred when staff provided ADL care with one-person assistance when the resident required two-person assistance. Findings include: Review of the admission Record for R14 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, multiple sclerosis, muscle wasting and atrophy, and acute and chronic respiratory failure with hypoxia. Review of the Significant Change Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/05/2026, revealed that section GG (Functional Abilities and Goals) documented that the resident had bilateral upper and lower extremity impairment and was dependent for toileting hygiene, personal hygiene, and rolling left and right on the bed. The MDS stated that dependent meant that the assistance of two or more helpers was required to complete the activity. Section H (Bladder and Bowel) documented that the resident was always incontinent of bladder and bowel. Review of the Progress Notes for R14 revealed an entry dated 05/06/2026 at 11:34 PM and titled N Adv-Left/Transfer Evaluation that included, Resident is not able to assist with repositioning in bed. Continued review of the Progress Notes for R14 revealed an entry dated 05/07/2026 at 11:00 PM and titled Incident Note that documented the nurse was called to the patient's room by a Certified Nurse Aide (CNA). The resident was lying on the floor next to his bed on his back with CNA BB standing over him and applying pressure to his bleeding forehead. The CNA reported that as she was changing the resident's linen after an incontinent episode, he rolled off the bed and hit his head on the side of the bed. A head-to-toe assessment was completed, vital signs were taken, the Nurse Practitioner was notified, and the resident was sent to the emergency room (ER) for evaluation. Further review of the Progress Notes for R14 revealed an entry dated 05/08/2026 at 4:04 AM and titled Health Status Note that documented the resident returned for the ER with right ankle sprain, abdominal wall contusion, and laceration repair to mid-dissolvable sutures to the forehead. Review of the ER record for R14, dated 05/07/2026, revealed the reason for the visit was a fall. The diagnoses were: fall from bed, laceration of the skin of the forehead, sprain and strain of the right ankle, contusion of the abdominal wall, and injury of the head. The record documented that a laceration repair was completed. In an interview on 06/09/2026 at 3:40 PM, Licensed Practical Nurse (LPN) CC stated that when she entered R14's room just after the fall on 05/07/2026, only one CNA was present, attempting to change his bed linens. She stated that a second staff member should have been present to assist.In a telephone interview on 06/09/2026 at 3:50 PM, CNA BB reported that at the time of R14's fall, she was changing him by herself and did not have another staff member present. She stated she was unable to keep him on the bed, and he fell to the ground. She stated she was unaware that the resident required a two-person assist. In an interview on 06/10/2026 at 10:05 AM, LPN CC stated R14 required two persons for assistance. She stated the resident had a fall from the bed when CNA BB was changing him unassisted and sustained a laceration on his forehead. She further stated that R14 was transported to the ER after the fall and received sutures to his forehead for a laceration. In an interview on 06/10/2026 at 11:50 AM, the Director of Nursing (DON) stated CNA BB was providing care for R14 unassisted when he fell from the bed. She stated the CNA did not provide care according to the resident's assessed needs. She further stated that education was provided to CNA BB after the incident. In an interview on 06/10/2026 at 12:30 PM, the Administrator explained that when CNA BB was changing R14, a sheet got tangled up, the CNA attempted to grab the resident, but was unable to keep him from falling to the floor. The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Administrator further stated that if R14 was assessed as needing two persons' assistance, her expectation was for two persons to provide assistance for R14 when changing his bed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of the facility policies titled Infection Prevention and Control Program and Laundry, the facility failed to follow infection control practices related to proper handling and transporting of soiled items throughout the facility and in the laundry room. The deficient practices had the potential to place the residents at risk of infections due to cross-contamination. The facility census was 158. Findings include:Review of the facility policy titled Infection Prevention and Control Program, revised on 02/20/2026, documented, . 12. Linens a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. b. Clean linen shall be separated from soiled linen at all times.Review of the facility policy titled Laundry, with a revised date of 10/2025, documented, Policy Explanation and Compliance Guidelines: . 3. Soiled laundry shall be kept separate from clean laundry at all times.Observation and joint interview on 06/10/2026 at 12:38 pm revealed that the Laundry Aide and Laundry Supervisor in the laundry room were removing clean towels from the washing machine and placing them in a wheeled wire bin to put in the dryer. During the process of putting the towels in the dryer, three clean towels fell from the pile, missing the wire bin, and landed on the floor. Both the Laundry Aide and the Laundry Supervisor were observed picking the towels up off the floor and placing them in the dryer. The Laundry Aide started the dryer. When asked about the towels that were picked up off the floor and placed in the dryer, the Laundry Supervisor revealed they should not have been placed in the dryer but should have been returned to the washing machine after landing on the floor. Joint Observation and interview on 06/11/2026 at 10:38 AM of Laundry Aide DD pushing a bin labeled soiled linens through C Hall with the top flap open and exposing the soiled items in the bin. When asked whether the bin lid should be closed, she stated, I got it, and closed it.Interview on 06/11/2026 at 11:47 AM with the Director of Nursing (DON) revealed it was best practice for staff to not push the bins labeled soiled linens throughout the hallways with the top off. Interview on 06/11/2026 12:04 PM with the Administrator revealed that it was not normal practice for soiled laundry bins to be pushed through the facility with the lids open, and it should not be done. She further revealed that the lid should be closed when going through the hall. The Administrator revealed that the laundry should not hit the floor and be put in the dryer, but should be re-washed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to ensure that one of 58 sampled residents (R208) received an accurate Minimum Data Set (MDS) assessment reflective of the resident's status at the time of the assessment. This deficient practice had the potential to place R208 at risk of inadequate care planning and interventions.Findings include:Review of the electronic medical record (EMR) for R208 revealed admission to the facility on [DATE] with diagnoses including, but not limited to, unspecified dementia, unspecified severity, with agitation, unspecified dementia, unspecified severity, with mood disturbance, and Parkinson's disease without dyskinesia, with fluctuations Further review of the EMR for R208 revealed the resident was discharged from the facility on 01/10/2026 with a 1013 Form (a legal document that authorizes a psychiatric hold and examination of someone experiencing a mental health crisis) related to behaviors. Review of the Discharge MDS assessment for R208, dated 01/10/2026, revealed section A (Identification Information) documented the resident had an unplanned discharge on [DATE] to a short-term general hospital. Section C (Cognitive Patterns) documented a staff assessment of mental status, which noted that the resident's short-term memory was okay and that he was independent in making decisions regarding daily tasks. No signs of delirium, disorganized thinking, or inattention. Section E (Behaviors) documented no hallucinations or delusions, no physical behavioral symptoms directed towards others, no verbal behavioral symptoms directed towards others, and no other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds).Review of the facility-provided document titled Form 1013-Certificate Authorizing Transport to Emergency Receiving Facility & Report of Transportation (Mental Health), for R208, dated 01/10/2026, documented that the resident appeared to be mentally ill and had expressed recent threats/acts toward others, and the resident had threatened others. Review of the progress notes for R208 revealed an entry dated 01/10/2026 at 7:04 AM of At approximately 0645, resident exhibited aggressive and violent behavior. Resident grabbed staff by the neck and attempted to strike staff with a glass cup. Resident is COVID-19 positive; education was provided regarding the need to remain in his room for isolation precautions. Resident refused redirection and became increasingly agitated. Resident barricaded the door, preventing staff from exiting the room. Staff member called out for assistance, and additional staff responded to de-escalate the situation and assist with staff safety. {sic}Further review revealed an entry dated 01/10/2026 at 7:08 AM of Patient was discharged from facility and sent to the hospital for physical and verbal aggression on multiple and towards other residents. Unable to console or redirect. Officered snacks and incontinent care, morning medications given, offered reading materials. All confutable sets were not successful. Resident started the aggression with the CNA then transfer to the nurse then other resident around him. Other resident encouraged to remain safe from aggressive behavior to avoid any injury. After writer grabbed by neck and nearly lifting me off my feet, police called and report given. Inhouse supervisor alerte4d of the situation and assist with situation keeping all other resident safe along with resident initiating violence. NP [Nurse Practitioner] called, order given to 1013 resident immediately charge nurse with [hospital name] given full report. 911 in the building residemt became voilence with male Ems [emergency medical services]. Resident deescalated with stand by deputy officer. Resident eventually calmed down to get in the stretcher and been rolled out of the building to get medical help needed to ensure the safety of itself and others. {sic}Continued review revealed an entry dated 01/10/2026 at 9:59 AM of Resident was transferred out of the facility due to escalating violent and aggressive behavior posing an immediate risk to staff safety. Within the past 24 hours, resident demonstrated severe behavioral disturbances. On the prior day, resident barricaded a CNA [Certified Nurse Aide] inside a room. Overnight, resident physically assaulted the nurse by grabbing (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her around the neck and choking her, forcefully bending her hand backward, and attempting to strike her with the other hand while holding a cup; the incident ended only after the nurse screamed for help. These actions constitute an immediate safety threat that exceeds the facility's capacity for safe behavioral management. The facility is unable to safely meet the resident's needs at this time. Resident requires transfer to a higher level of care with specialized psychiatric and behavioral services to ensure safety of the resident and others. {sic}In an interview on 06/11/2026 at 11:33 AM, the Social Service Director (SSD) confirmed that the MDS Section E was coded incorrectly. She stated that the section was completed by the Social Service Assistant. In an interview on 06/11/2026 at 11:40 AM, the Social Service Assistant (SSA) AA stated that she reviewed the progress notes and care plan to code the sections on the MDS. She states that it was important to complete the MDS correctly. The SSA AA also stated that the MDS should reflect the current resident condition. The SSA AA confirmed that section E of R208's Discharge MDS was not coded correctly. In an interview on 06/11/2026 at 12:07 PM, the Director of Nursing (DON) revealed she expected the MDS to be coded accurately. The DON stated that it was important for the MDS to accurately reflect the resident's condition and care. In an interview on 06/11/2026 at 12:34 PM, the Administrator stated she expected staff to code the MDS assessment accurately and follow the regulatory guidelines.