

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Park Highlands Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 711 Lucas Drive Athens, TX 75751	
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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to participate in the development and implementation of his or her person-centered care plan for 3 of 5 dialysis residents (Residents #6, #46, #47) reviewed for the right to participate in planning care. The facility failed to ensure Resident #6, Resident #46 and Resident #47 were included in the development and implementation of their personal care plans. This failure could place residents at risk of not receiving adequate and individualized care while residing at the facility. Findings included: Record review of Resident #6's face sheet dated 06/02/2026 indicated Resident #6 was a [AGE] year-old male and admitted on [DATE] and re-admitted on [DATE]. His diagnoses included ESRD (final stage of chronic kidney disease, where the kidneys can no longer function adequately to sustain life without treatment), type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and dependence on renal dialysis (is a type of treatment that helps your body remove extra fluid and waste products from the blood when the kidneys are not able to) and chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe). The record indicated Resident #6 was his own responsible party. A record review of a quarterly MDS dated [DATE] indicated Resident #6 had a BIMS score of 15 which indicated his cognition was intact. A record review of doctor orders for Resident #6 indicated dialysis ordered Tuesday, Thursday, and Saturday at a local hemodialysis facility start date of 02/06/2025. A record review of progress notes dated 08/19/2025 to 06/03/2026 for Resident #6 indicated a copy of the baseline care plan was provided to the resident on 08/19/2025. There were no other documentations regarding care plans, care plan meetings scheduled or attended and reflected no documentation the resident had been notified of care plan meetings. A record review of a Care Conference Assessments in the electronic record for Resident #6 indicated the most recent care plan meeting was held on Thursday 03/05/2025. Record review of Resident #46's face sheet dated 06/02/2026 indicated Resident #46 was a [AGE] year-old female and admitted on [DATE] and re-admitted [DATE]. Her diagnoses included ESRD, type 2 diabetes mellitus, and dependence on renal dialysis and acute and chronic respiratory failure (occurs when the lungs cannot release enough oxygen into your blood), major depressive disorder (serious mood disorder that affects how a person feels, thinks, and behaves, often leading to emotional and physical problems). The record indicated Resident #46 was her own responsible party. A record review of a quarterly MDS dated [DATE] indicated Resident #46 had a BIMS score of 15 which indicated her cognition was intact. A record review of doctor orders for Resident #46 indicated renal dialysis ordered Tuesday, Thursday, and Saturday at a local hemodialysis facility with a start date of 02/06/2025. A record review of progress notes dated 12/03/2025 to 06/03/2026 for Resident #46 indicated a copy of the baseline care plan was provided to (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy Comprehensive Care Planning indicated: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. The facility will provide the resident and resident representative, if applicable with advance notice of planning conferences to enable resident participation.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate the assessment of 1 of 2 residents (Resident #9) reviewed for the pre-admission screening and resident review (PASARR) program and PASARR assessments and evaluations. The facility failed to ensure Resident #9's PASARR Level 1 screening was accurately coded to reflect he had indicators of mental illness. This failure could place residents with psychiatric diagnoses at risk for not being evaluated for PASARR services and potentially not receiving services for care and treatment. Findings included: A record review of a face sheet dated 06/02/2026 indicated Resident #9 was a [AGE] year-old male who admitted to the facility 04/30/2026. He had diagnoses which included PTSD (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and depression (a serious, common mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). A record review of hospital records dated 04/23/2026 indicated Resident #9 had diagnoses which included PTSD and depression. A record review of the admission MDS dated [DATE] indicated Resident #9 had diagnoses of PTSD and depression. A record review of Resident #9's physician's orders dated 06/02/2026 indicated he had diagnoses of PTSD and depression. A record review of Resident #9's PASRR Level 1 screening dated 04/29/2026 indicated he had no indicators of mental illness. During an interview on 06/02/2026 at 04:12 PM, the MDS Coordinator said she was responsible for ensuring the PASARR Level 1 screening was completed and was accurate. She said she should have noticed Resident #9's PASRR Level 1 screening was incorrectly coded and that it did not reflect he had indicators of mental illness. The MDS Coordinator said she should have notified the local authority about the incorrect PASARR Level 1 screening. The MDS Coordinator said the failure to address the inaccurate PASARR Level 1 screening resulted in Resident #9 not being evaluated for PASARR services and possibly not receiving PASRR services. A review of the facility's policy dated 03/6/2019 and titled PASARR Level 1 Screen Policy and Procedure indicated the following: Procedure: 2. The PL (PASARR Level) 1 Screening Form is completed by the RE (referring entity) using the paper copy of the PL 1 Screening Form. 3. The Facility will review the PL 1 Screening Form for completion and correctness prior to admission and submit the PL 1 form per regulations. and review each item on the PL 1 to ensure accuracy and prevent a regulatory problem.		

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility, with a capacity of more than 120 beds, failed to employ a qualified social worker on a full-time basis for 1 of 1 social services staff reviewed for qualifications of Social Worker (SW). The facility failed to employ a SW on a full-time basis. This failure could place the residents at risk of not receiving social services to meet their needs. Record review of the Facility Summary Report from Tulip (Texas Unified Licensure Information Portal) dated 12/31/2018 revealed the facility had a maximum capacity of 132 beds. During a personnel record review on 06/03/2026 the file indicated the SW was hired on 01/31/2022. The record indicated she worked 16 hours per week. During an interview on 06/02/2026 at 4:37 PM, the SW said she only worked 16 hours a week and was employed part time and she was not aware that this facility had to have a full-time social worker During an interview on 06/02/2026 at 4:45 PM, the administrator said the facility was licensed for 132 beds. She said the census had been down, so she had only hired SW part-time.		

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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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 4 residents (Resident #9) reviewed for care plans. The facility failed to ensure Resident #9's care plan addressed diagnoses of PTSD and depression, and the prescribed use of psychoactive drugs. This failure could place residents with diagnoses of mental illness and psychoactive drug use at risk for not receiving care and services to meet medical, mental, psychosocial, and nursing needs. Findings included: A record review of a face sheet dated 06/02/2026 indicated Resident #9 was a [AGE] year-old male who admitted to the facility 04/30/2026. He had diagnoses which included PTSD (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and depression (a serious, common mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). A record review of the admission MDS dated [DATE] indicated Resident #9 had diagnoses of PTSD and depression. The MDS: Section V - Care Area Assessment Summary indicated Resident #9 triggered for psychosocial well-being, mood state, and psychotropic drug use. A record review of physician's orders dated 06/02/2026 indicated Resident #9 had orders for 3 (three) psychoactive drugs dated 04/30/2026 which included divalproex sodium 250mg - 1 tablet daily for mood stabilizer, citalopram 40 mg tablet - 1 tablet daily for depression, and trazadone (an antidepressant) 100mg tablet - 1 tablet daily for insomnia. A record review of Resident #9's comprehensive care plan with an initiation date of 05/01/2026 and a completion date of 05/15/2026 indicated there were no documented concerns or interventions to address Resident #9's mental illness diagnoses and psychoactive drug use. During an interview on 06/02/2026 at 04:12 PM, the MDS Coordinator said she was responsible for coordinating the development of the residents' care plans. She said Resident #9's care plan should have addressed his diagnoses of PTSD and depression. She said Resident #9's use of the psychoactive medications, divalproex sodium, citalopram, and trazadone should also have been addressed in his care plan. The MDS coordinator said it was an oversight. She said Resident #9's care plan was important for communicating concerns regarding his diagnosis of PTSD and interventions to address those concerns. During an interview on 06/02/2026 at 04:22 PM, the SW said The MDS Coordinator was responsible for ensuring the care plans were complete and addressed the resident's medical and psychosocial health needs. A record review of the facility's undated policy titled Comprehensive Care Planning indicated the following: The facility will develop and implement a person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following- The surfaces that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychoactive well-being; .		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 2 residents (Resident #9) reviewed for trauma-informed care. The facility failed to ensure Resident #9 had a trauma screening completed upon admission to the facility that identified possible triggers when Resident #9 had a history of trauma. This failure could place residents with a history of trauma at risk for psychological distress due to re-traumatization. The findings included: A record review of a face sheet dated 06/02/2026 indicated Resident #9 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). A record review of the admission MDS assessment dated [DATE] reflected Resident #9 had clear speech and was understood by others. The MDS reflected Resident #9 was able to understand others. The MDS reflected Resident #9 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS reflected Resident #9 had no behaviors or refusal of care. The MDS reflected Resident #9 had an active diagnosis of PTSD. A record review of Resident #9's initial social history dated 05/12/2026 indicated the trauma informed care section was not completed until 06/02/2026 after surveyor intervention. During an interview on 06/02/2026 at 04:22 PM, the SW said she was responsible for completing the Trauma Informed Care section of the Social History Assessment. The SW said she went by the PASARR completed by the hospital and did not notice Resident #9 had a diagnosis of PTSD in the hospital records and on facility's admission records. The SW said she did not notice that Resident #9 triggered for PTSD, psychosocial well-being, and mood state on the admission MDS dated [DATE]. The SW said it was important to ensure residents were screened for a history of trauma and potential triggers were identified to minimize or prevent triggers that could cause re-traumatization. A record review of the facility's policy titled Trauma Informed Care dated October 2022 indicated the following: The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Assessment: Facilities should use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences. This would include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument, admission Assessment, the history and physical, the social history/assessment, and others.		

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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 implement infection control practices designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Residents #42) reviewed for infection control. SA-A did not wash or sanitize her hands, used the same pre-moistened wipe to cleanse multiple areas, and did not change gloves while performing incontinent care for Resident #42 and after disposing of contaminated PPE. SA-A touched clean items with contaminated gloves. SA-A did not remove and dispose of PPE (gown and gloves) and perform hand hygiene before leaving Resident #42's room. These failures could place residents at risk of exposure to and transmission of communicable diseases and infections. Findings included: A record review of a face sheet date 06/02/2026 indicated Resident #42 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included Fournier's gangrene (a rare, life-threatening form of necrotizing fasciitis [flesh-eating disease] that affects the genitals and the area between the genitals and anus) and left buttock pressure ulcer. A record review of the annual MDS dated [DATE] indicated Resident #42 had diagnoses of Fournier's gangrene and a stage IV pressure ulcer of the left buttock. The MDS indicated Resident #42 was incontinent of bowel and bladder, non-ambulatory, and had a BIMS score of 5 indicating his cognition was severely compromised. A record review of Resident #42's physician's orders dated 06/02/2026 indicated he had an order dated 02/06/2026 for Enhanced Barrier Precautions (EBP). The physician's orders indicated Resident #42 had a pressure ulcer on the left buttock. A record review of Resident #42's care plan dated 04/02/2024 indicated he required EBP and included an intervention to perform hand hygiene prior to entering and prior to exiting his room. During an observation and interview on 06/02/2026 at 10:30 AM, SA-A was observed putting on a disposable gown and gloves outside Resident #42's room. SA-A did not wash or sanitize her hands before putting the gloves on. Resident #42 was noted to have an EBP sign posted at the entrance to his room. SA-A said Resident #42 needed incontinent care. SA-A entered Resident #42's room and told him what she was going to do. SA-A folded back bed linen and opened Resident #42's brief to expose his lower body. SA-A obtained a disposable wipe from a bag and used the same wipe to clean both sides of Resident #42's pelvic region and groin area. SA-A placed the wipe in a plastic trash bag lying on the foot of the bag. SA-A then turned Resident #42 to his side, obtained a clean wipe, cleaned his buttocks, and removed the soiled brief from under the resident. SA-A put the soiled brief and wipe into the bag and without changing gloves and performing hand hygiene, SA-A put a clean brief on Resident #42. Still wearing the contaminated gloves, SA-A replaced the bed covers over Resident #42, repositioned him over the bed table, handed Resident #42 his call light and placed the bed control within his reach. SA-A pulled the room divider curtain back and picked up the plastic bag containing the soiled wipes and brief and left the room while still wearing the PPE (gown and gloves). SA-A walked down the hall, stopped at the common area by the nurses' station, and removed her gloves and gown. SA-A wadded the gown and gloves together and carried the contaminated gown, gloves, and trash bag around the corner to the shower room where she disposed of them. SA-A was observed to leave the shower room without performing any hand hygiene. SA-A said she forgot to obtain a clean wipe each time she moved from cleaning one area of the body to another. She said she forgot to change her gloves before putting on a clean brief on Resident #42. SA-A said she should have removed her gown and gloves while in the resident's room, placed them in the trash bag, and washed her hands. SA-A said she should not have worn the contaminated gown and gloves out of the (continued on next page)		

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