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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675915	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Park Place Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Fm 971 Georgetown, TX 78626	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #3) of three residents reviewed for quality of care. The facility failed to schedule an appointment in a timely manner with a neurologist as ordered by Resident #3's cardiologist. This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization . Findings included: Review of Resident #3's undated face sheet reflected a [AGE] year-old male who was readmitted to the facility on [DATE], with an original admitted [DATE]. Resident #3's diagnoses include: sleep apnea (pauses/stops in breathing while sleeping), chronic obstructive pulmonary disease (difficulty breathing), type II diabetes, mild cognitive impairment of uncertain or unknown etiology, cerebral infarction (interrupted blood flow to the brain causing brain cell death) and PTSD (a mental health condition that some develop after a traumatic event). Review of Resident #3's five day scheduled assessment MDS, dated [DATE], reflected a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident #3's EHR reflected a referral was faxed on 10/7/24 to the facility by the cardiologist for an appointment with a neurologist. Review of Resident #3's facility Physician Orders, revision date of 10/11/24, reflected an order for a neurologist visit. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/23/24 at 10:44 am with Resident #3 revealed he was having trouble getting the facility to make an appointment, his cardiologist wants him to see a neurologist. Resident #3 stated the last appointment he had with the cardiologist he was given a hard copy of the referral order which he gave to the nurses. The first time the SW faxed the referral they put he had dementia as a diagnosis which I do not have, so the neurologist would not see him. Supposedly, the SW faxed a new referral but said they are not responding. Resident #3 stated he had a history of strokes, which is the reason he wanted the appointment. During interviews on 11/23/24 at 3:29 pm and on 11/25/24 at 12:25 pm, the facility SW stated the first time she faxed the neurologist had been on 10/9/24 after she became aware of the cardiologist having given a referral order. The SW believed the cardiologist made the referral because Resident #3 requested to see the neurologist. She stated the first fax request was refused because they did not treat the diagnoses listed on the referral that the cardiologist had given for Resident #3. The SW stated she wondered if they just do not want to see him because he can be a difficult patient and they had seen him before, so they were aware. On 10/11/24 she sent another fax requesting an appointment with different diagnoses, both faxes had her number and she had requested a call back to make an appointment. She stated they never called her back. The SW stated she was waiting for the call from them because that named neurologist was included on the referral order. She left voicemails on the answering machine on 11/01/24 and 11/18/24 asking for a call back, but she had not documented the calls. She stated on 11/21/24 she and Resident #3 called the neurologist together and left another voicemail. The SW stated she did not call the cardiologist to request a referral to a different neurologist because this specific cardiologist is on the order . During an interview on 11/25 10:40 am with Certified Medical Assistant at Resident #3's cardiologist office stated there were many doctors these days that were not accepting new patients. She stated they frequently would send the referral to a different doctor if they were notified the one listed was not available. During an interview on 11/23/24 at 2:23pm and on 11/25/24 at 10:15 am the facility DON stated the SW had been trying to get Resident #3 an appointment with a neurologist but the ones the SW had reached had declined. The DON stated she did expect physician orders to be implemented timely but Resident #3 had been hospitalized since the referral and they did not continue to try to do a referral while the resident was not in the facility. During an interview on 11/25/24 at 10:05 am the Adm stated the referral for Resident #2 was sent twice but the neurologist did not like the diagnoses that were on the referral. She stated in addition Resident #3 had gone to the hospital a couple of times so no referrals occurred during that time. Adm stated they do referrals regularly for residents, but she knows it takes a long time to get an appointment with a neurologist. During an interview on 11/25/24 at 1:59 pm, Resident #3's NP stated the referral to the neurologist should have followed up on sooner. He stated he would work with the SW and the facility to make sure the appointment was made. Review of the facility policy, undated, titled Resident Rights reflected the following: Planning and implementing care - The resident has the right to be informed of, and participate in, his or her treatment, including: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The right to be fully informed in language that he or she can understand his or her total health status, including but not limited to, his or her medical condition. 2. The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. b. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. c. The right to be informed, in advance, of changes to the plan of care. d. The right to receive the services and/or items included in the plan of care. e. The right to see the care plan, including the right to sign after significant changes to the plan of care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on observations, interviews, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 3 residents (Residents #3) reviewed for quality of care. The facility failed to implement Resident #3's Care Plan which included the use of a CPAP for sleep apnea. This failure could place residents at risk of not receiving necessary medical care, a decrease quality of sleep and cardiovascular impairments. Findings included: Review of Resident #3's undated face sheet reflected a [AGE] year-old male who was readmitted to the facility on [DATE], with an original admitted [DATE]. Resident #3's diagnoses include: sleep apnea (pauses/stops in breathing while sleeping), chronic obstructive pulmonary disease (difficulty breathing), type II diabetes, mild cognitive impairment of uncertain or unknown etiology, cerebral infarction (interrupted blood flow to the brain causing brain cell death) and PTSD (a mental health condition that some develop after a traumatic event). Review of Resident #3's five day scheduled assessment MDS, dated [DATE], reflected a BIMS score of 10, indicating moderate cognitive impairment. Section O (Special Treatments, Procedures, and Programs) did not include the use of a CPAP. Review of Resident #3's care plan, updated 10/29/24, reflected a focus area regarding Resident #3's use of a CPAP/BIPAP during sleep for sleep apnea. The date of initiation of the focus is listed as 10/29/24. Review of Resident #3's Physician Order Summary, undated, reflected an order to apply CPAP at night. The order was discontinued 4/29/24. Review of Current and Active Physician Orders revealed there was not a current order for a CPAP. During an observation on 11/23/24 at 10:50 am of Resident #3's room, revealed a box of items and in the room's closet there was not a CPAP machine in the room. During an interview on 11/23/24 at 10:44 am with Resident #3 revealed he had concerns that he no longer had his CPAP machine. He stated when he changed his room last time, they did not bring the CPAP to his new room. Resident #3 stated he sometimes felt like he needed to use the CPAP, but he could not now. Resident #3 stated they did not ask him if he wanted to use it anymore. During an interview on 11/23/24 at 2:23 pm and on 11/25/24 at 10:15 am the facility DON stated Resident #3 had not used a CPAP since she had been working at the facility the last couple of months. She stated she has not seen any clinical indications that he needs a CPAP machine. The DON stated she did not know if Resident #3 had a diagnosis of sleep apnea. She stated she did not know that Resident #3's care plan included the use of a CPAP as it predates her employment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/24 at 10:05 am the Adm stated Resident #3 does not have a current order for the CPAP to be offered, but they plan to add it as a prn order. She did not know why it was discontinued but suspected probably because he was noncompliant. Adm stated she did not know that the care plan included the use of the CPAP. She does expect the care plan to be followed. During an interview on 11/25/24 at 1:59 pm, Resident #3's NP stated he was not aware until recently that the CPAP order had been discontinued. He had thought the CPAP was being offered nightly but knew Resident #3 frequently refused treatments. The NP stated the CPAP had been found in the resident's previous room. The NP stated that he knew the CPAP was previously in Resident #3's room when he would visit with the resident because they had discussed if he was utilizing the CPAP and Resident #3 stated he did not tolerate the CPAP . The NP stated they will be implementing a PRN order. Review of the facility policy, undated, titled Resident Rights reflected the following: Planning and implementing care - The resident has the right to be informed of, and participate in, his or her treatment, including: 1. The right to be fully informed in language that he or she can understand his or her total health status, including but not limited to, his or her medical condition. 2. The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. b. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. c. The right to be informed, in advance, of changes to the plan of care. d. The right to receive the services and/or items included in the plan of care. e. The right to see the care plan, including the right to sign after significant changes to the plan of care. Review of the facility policy, undated, titled Comprehensive Care Planning reflected the following: The services provided or arranged by the facility, as outlined by the comprehensive care plan, will meet professional standards of quality. And In situations where a resident's choice to decline care or treatment (e. g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan will identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.