

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 01/28/2025
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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269</p> <p>Based on, interview, and record review the facility failed to ensure residents were free from neglect for 1 of 4 residents (Resident #1) reviewed for abuse and neglect.</p> <p>CNA A and LVN B failed to check on Resident #1 on the night of 01/09/2025 from about 10:00 pm through the morning of 01/10/2025 at about 4:40 am, leaving Resident # 1 unattended for about 6 hours. Resident #1 fell on the floor and was on the floor the entire night unattended by staff. When Resident #1 was found on the morning of 01/10/2025, he was noted with abrasion at his left arm, combative, angry and speaking Spanish.</p> <p>The noncompliance was identified as PNC. The IJ began on 01/09/2025 and ended on 01/17/2025. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of Neglect, injury, and psychosocial harm.</p> <p>Finding included:</p> <p>Review of Resident #1's undated care plan reflected a [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with late onset, Generalized Anxiety disorder, Dementia in other diseases classified elsewhere.</p> <p>Review of Resident #1's significantly change in status MDS assessment, dated 12/24/24, reflected a BIMS score of 99, indicating he had a severe cognitive impairment. It was also noted a staff assessment for mental status was conducted which indicated short and long-term memory problem and cognitive skills for daily decision-making being moderately impaired. Section GG -Functional Abilities of the MDS reflected Resident #1 required supervision or touching assistance with toileting.</p> <p>Review of Resident #1's quarterly care plan, initiated 10/15/2024, reflected Resident #1 had communication problems, with intervention to anticipate and meet needs. Resident #1 was on the secure unit related to diagnosis of dementia and risk for elopement. Resident was at risk for fall related to gait/balance problems, with intervention to anticipate and meet resident's needs. Resident #1 had impaired cognitive function/dementia or impaired thought processes.</p> <p>Review of Resident #1's fall risk assessment dated [DATE] reflected a score of 13 which indicated high risk.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's progress notes dated 10/10/2025 at 05:41 am written by LVN B reflected</p> <p>At 0440 resident was found on the floor, near the toilet door by the CNA (xx). He sustained an injury (abrasion) to his left elbow, and also refused further assessments as he was being combative. He was not able to tell the reason for his fall as he just kept on speaking in Spanish. Upon routine care no other injury was noted, no vitals were documented. Hospice nurse (xxx), DON (xxx), RP (xxx) were being notified. Wound is left too air dry, and resident is being monitored for any changes.</p> <p>Review of Resident #1's progress notes dated 10/10/2025 at 05:43 am reflected:</p> <p>.The fall caused an abrasion to left elbow. Size of the abrasion in cm: 1-2cm.Painful, At 0440 resident was found on the floor, near the toilet door by the CNA (XX). He sustained an injury (abrasion) to his left elbow, and also refused further assessments as he was being combative.</p> <p>Review of written statement provider by Administrator, undated reflected the following, On 1/10/25, Administrator was notified of allegation of neglect from resident [family member]. Allegation made regarding potential neglect of resident not being rounded overnight for six hours. Administrator reviewed cameras with DON and identified resident fell and remained on floor from around 10:20pm until around 5am. Resident's room had light on all night, resident was laying on floor half on fall mat and head closest to resident bathroom. DON and administrator assessed the room to identify if staff opened door if they could easily see resident; both identified if you crack open the door you can see resident if he is lying in bed. According to camera footage, the resident was laying on the ground from stated hours and would not have been witnessed in his bed.</p> <p>During an observation on 01/28/2025 at 11:26 am revealed Resident #1 lying in bed. Bed was noted in the lowest position with floor mat present. Attempted to interview Resident #1 and he was not responding appropriately.</p> <p>During an interview on 1/28/2025 at 12:44 pm CNA A stated she worked the 7pm to 7 am shift on the night of 1/09/2025 to the morning of 1/10/2025 on the secure unit. CNA A stated she got to work late that evening but could not remember how late she was. CNA A stated LVN B had already done the first checks on the residents when she got at the Facility. CNA A stated she and LVN B did their second check at about 11:30 pm but she did not check Resident #1. CNA A said she saw Resident #1 lying in bed at about 1:30 am. CNA A stated, at about 4:30 am while making her rounds, she found Resident #1 on the floor next to the bathroom door and notified LVN B. CNA A stated LVN B went to Resident #1's room and assessed Resident #1. CNA A stated she and LVN B provided care for Resident #1 and put him back in the bed. CNA A stated she did not know how long Resident #1 was on the floor. CNA A stated staff were supposed to check on the residents every 2 hour and if it was not done, that was neglect. CNA A stated she was aware Resident #1 had camera in his room, the sign was posted at the door. CNA A stated she was suspended on 01/10/2025 and terminated a week later.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/28/2025 at 1:21 pm LVN B stated she worked the 6pm to 6 am shift on the night of 01/09/2025 to the morning of 01/10/2025 on the secure unit. LVN B stated she checked Resident #1 on 01/09/2025 at about 10:00 pm and the next time she saw Resident #1 was when she was notified by CNA A that the resident was on the floor on the morning of 01/10/2025 at about 4:40 am. LVN B stated she tried to assess Resident #1, but he was refusing care, she noted bruise and scratch on Resident #1's hand. LVN B stated they were supposed to make rounds/checks every 2 hours, not making rounds or frequent checks on the residents was considered neglect. LVN B stated it was not ok for a resident to fall and remain on the floor for hours because it could lead to injuries and concussion. LVN B stated once Resident #1's door was opened, staff would see him on the bed or on the floor. LVN B stated the night was busy. LVN B stated she was suspended on 01/10/2025 and terminated a week later.</p> <p>During an interview on 01/28/2025 at 2:58 pm the DON stated she watched the video footage provided by Resident #1's family dated 01/09/2025 through 01/10/2025. The DON stated, according to the time stamp on the video footage, Resident #1 got out of bed on 01/09/2025, took himself to the toilet, on his way back to bed, fell at about 10:15 to 10:20 pm and remained on the floor, floor mat present, his head was towards the bed and the legs to the bathroom, until about 4:40 am on 01/10/2025 when he was found by staff. The DON stated, Resident #1 made several attempts to get back up and repositioned himself but was not successful. The DON stated, according to the video footage, CNA A entered Resident #1's room at about 4:40 am on 01/10/2025 and alerted LVN B. The DON stated LVN B attempted assessing Resident #1, both staff cleaned Resident #1 and helped him back to bed. The DON stated staff were expected to check on residents frequently, six hours was a long time not to check on a Resident. The DON stated once Resident #1's door was opened, the staff would see him on the floor or on his bed which indicated he was not checked on by staff. The DON stated both staff were suspended pending investigation and terminated after viewing of the video footage provided for the family. She stated Staff were in-serviced on abuse and neglect and making frequent checks on Residents. The DON stated Resident #1's medications were reviewed by hospice.</p> <p>During an interview on 01/28/2025 at about 3:35 pm the Administrator stated she was made aware by Resident #1 family that he fell the night of 01/09/2025 at about 10:20 pm and remained on the floor until 01/10/2025 at about 4:40 before staff found him. The Administrator stated she watched the video footage provided by family along with the DON. The Administrator stated the video camera did not face the doorway, but no staff was seen in Resident #1's room for about 6 hours. The Administrator stated from the location of Resident #1's bed, even if his door was cracked open a little, the staff would have seen him on the bed or on the floor. The Administrator stated she did not believe the staff had checked on Resident #1 for the period being reviewed. The Administrator stated staff were expected to make frequent checks on residents. She stated there was no facility policy on how frequent staff should check on the residents, but 6 hours was a long time to not check on the resident. The Administrator stated both CNA A and LVN B were suspended immediately pending investigation, staff were educated on abuse and neglect and frequent rounding on residents. She stated Resident #1 was assessed; the facility completed full skin sweep of all the residents on the secure unit. The Administrator stated CNA A and LVN B were terminated. The Administrator stated Resident #1 was later sent to the ER for further evaluation but came back quickly the same day. During an interview on 01/30/2025 at about 1:51 pm, Resident #1's family stated she followed Resident #1 to the local ER and CAT scan (is an imaging test that uses a combination of x-ray and a computer to create detailed picture of organs, bones, and other tissue inside the body) of his head came back negative. She stated the Resident was fine and was transferred back to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/30/2025 at about 1:51 pm, Resident #1's family stated she followed Resident #1 to the local ER and CAT scan (is an imaging test that uses a combination of x-ray and a computer to create detailed picture of organs, bones, and other tissue inside the body) of his head came back negative. She stated the Resident was fine and was transferred back to the facility.</p> <p>During interview on 01/28/2025 from 11:41 am through 2:49 pm with 1 ADON, 1 RNs, 2 LVNs, 3 CNAs , 1 HA, the Staffing Coordinator revealed they were in-serviced on abuse and neglect and making frequent rounds/checks on residents after the incident with Resident #1 when he was found on the floor. Staff stated they were supposed to make rounds every 2 hours alternating trips.</p> <p>Review of the facility's in-services reflected an in-service dated 01/10/2025 presented by the DON for all facility staff.</p> <p>In-service: Attached lessons</p> <p>-- Neglect Reporting</p> <p>--Frequent Rounding on Residents</p> <p>Review of CNA A and LVN B's personnel files reflected they both were terminated on 01/17/2025.</p> <p>Review of the facility's investigation dated 01/17/2025 reflected a thorough investigation was completed, and the allegation of was injury of Unknown injury was confirmed.</p> <p>Review of the facility's Policy revised 09/09/24 titled Abuse/Neglect reflected:</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Training</p> <p>The facility will train through orientation and on-going in-services on issues related to abuse/neglect prohibition practices regularly.</p> <p>Protection</p> <p>The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property investigation.</p> <p>1. Allegations of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property will remain confidential.</p>		