STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675915	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Care Center	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 4 (400) halls observed for housekeeping and maintenance services. The facility failed to ensure there were not a black circular substance under the wallpaper in three residents (Resident #1, Resident #2, and Resident #3) rooms. This deficient practice could place residents at risk of living in an unclean and unsanitary environment and result in potential health issues or affecting the airway. The findings were: Record review of Resident #1's face sheet, dated 05/21/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (memory, thinking, difficulty), anemia (not enough healthy red blood cells), type 2 diabetes mellitus without complications (high blood sugar), hyperlipidemia (high cholesterol), hypertension (high blood pressure), kidney disease, and hypertensive chronic kidney disease (damage to kidneys due to chronic high blood pressure). Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 99 indicating she was unable to complete the interview. Record review of Resident #2's face sheet, dated 05/21/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included dementia (memory, thinking, difficulty), hypertension (high blood pressure), Alzheimer's disease (progressive disease that destroys memory and other important mental function), anxiety (feeling of uneasiness or worry), Migraine, repeated falls, insomnia (difficulty sleeping), muscle weakness, history of falling, hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), and vitamin D deficiency. Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 03 indicating severe cognitive impairment. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's face sheet, dated 05/21/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included metabolic encephalopathy (brain disease), hyperlipidemia (high cholesterol), hypertension (high blood pressure), other forms of tremor, and benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate). Record review of Resident #3's admission MDS dated [DATE] revealed Resident #3 did not have a BIMS score. Record review of Resident #3's progress notes dated 05/21/2025 revealed Resident #3 rarely/never made self-understood. During an interview with the Housekeeper on 05/21/2025 at 10:02 am revealed that the wall in the housekeeping storage room was tore out and had mold on the walls. She said that she informed MAIN, and nothing had been done. She said that it had been that way for about three or four months. During an interview with the MAIN Director on 05/21/2025 at 2:3 he said that Resident #1, Resident #2, and Resident #3's rooms on the 400-hall had mold behind the wallpaper. He said there was not a resident in one of the rooms. He said the residents and staff could get sick from the mold. He said that he informed the ADM and had not gotten a response. He said that he informed the ADM on 04/28/2025. He said that he had torn the wallpaper and started to take it off, saw the mold, and let the facility know. Observation of 400 hall on 05/21/2025 at 2:53 PM revealed that there was a black circular substance of different sizes underneath the wallpaper in Resident # 1, Resident #2, and Resident #3's room. Interview attempted with Resident #2 on 05/21/2025 at 2:53 revealed she would only say she was fine and was just resting. During an interview with the DON on 05/21/2025 at 3:07pm she said that she had not gotten any complaints about mold. She said that she had not heard from MAIN regarding any mold. She said if she thought there was mold in a resident's room she would move the resident to another room. She said mold was black and furry. The DON stated that the picture shown to her of the rooms looked like mold. She said that mold could cause health issues. During an interview on 05/21/2025 at 3:33pm, the ADM stated that the maintenance person had not told her about mold in rooms. She said if she had any suspicion of mold the resident would be taken out of the room. She said that she could not tell if it was mold in the pictures from the room because she was not a mold expert. She said that MAIN was responsible for letting her know so the facility could send it up and get someone out to check it. She said that she would call someone to inspect it. She said that mold or mildew could affect the airway. Interview attempted with Resident #1 on 05/21/2025 at 4:04pm was unsuccessful. Resident #1 started talking about her glasses and having an appointment. Interview attempted with Resident #3 on 05/21/2025 at 4:20pm revealed he did not want to talk to the surveyor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident Rights Policy not dated revealed: The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to the state survey agency within five working days of the incident for two (2) of five (5) residents reviewed for abuse and neglect. (Resident #2 and Resident #4). The facility failed to thoroughly investigate two facility reported incidents regarding Resident #2 and Resident #4 within five (5) days regarding allegations of neglect and injury of unknown origin. This deficient practice placed all residents at risk of harm form neglect due to not having a thorough investigation done for facility reported incidents. Findings Include: Record review of Resident #2's face sheet, dated 05/21/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included dementia (memory, thinking, difficulty), hypertension (high blood pressure), Alzheimer's disease (progressive disease that destroys memory and other important mental function), anxiety (feeling of uneasiness or worry), Migraine, repeated falls, insomnia (difficulty sleeping), muscle weakness, history of falling, hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), and vitamin D deficiency. Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 03 indicating severe cognitive impairment. Record review of Resident #4's face sheet, dated 05/21/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included atrial fibrillation (abnormal heart rhythm), obesity, kidney disease, hypertension (high blood pressure), hypertensive chronic kidney disease (damage to kidneys due to chronic high blood pressure), heart disease, lymphedema (localized swelling), constipation, and impulse disorder (inability to resist harmful urges leading to behaviors that can negatively impact oneself or others). Record review of Resident #4's Quarterly MDS dated [DATE] revealed Resident #4 had a BIMS score of 15 indicating intact cognitive response. Review of the facility's Investigation Report provided on 05/21/2025 reflected a report was submitted by the ADM to the state agency on 05/16/2025 at 8:22 AM for Resident #4 with an allegation of neglect. Schedules, and investigation report, provided to surveyor revealed that CNA C and CNA D who worked with Resident #4 when the incident occurred did not have documented interviews regarding the allegation of neglect. The findings were not submitted to HHSC within 5 days. The investigation report also revealed that there was no documentation as to the findings were unfounded. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Investigation Report provided on 05/21/2025 reflected a report was submitted by the ADM to the state agency on 05/10/2025 at 6:37 PM for Resident #2 with an allegation of injury of unknown origin. Schedules, and investigation report provided to surveyor revealed that RN A and MA B who worked with Resident #2 when the incident occurred did not have documented interviews regarding the allegation of injury of unknown origin. The findings were not submitted to HHSC within 5 days. The investigation report also revealed the findings were inconclusive. Record Review of the Self-Reporting Protocol/Neglect and/or Injury of Unknown Origin checklist dated 05/16/2025 revealed that the ADM did not complete interviews with staff who worked with Resident #4 regarding the allegation of neglect. Record Review of the Self-Reporting Protocol/Neglect and/or Injury of Unknown Origin checklist dated 05/10/2025 revealed that the ADM checked off that she interviewed staff about the injury of unknown origin for Resident #2. No staff interviews were in the documents provided to the surveyor. During an interview with the ADM on 05/21/2025 at 3:33pm, she stated that she did interviews with RN A, MA B, CNA C and CNA D that worked with the residents at the time and that they were in the binder. The only staff interview that was in the binder was for LVN C She said if they were not in the binder then she had them in her office. She did not remember what the staff stated in their interview. Surveyor requested those interviews and ADM did not provide them. She also said that she had completed the investigations. Record review of the incident intake Binders for Resident #2 and Resident #4's incidents revealed there were no staff interviews in the binders. Requested the interviews from the ADM and they were not provided at exit. Record review of the Facility Abuse and Neglect Policy not dated revealed the facility will determine the direction of the investigation based on a thorough examination of events. The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form.