

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  07/10/2025
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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the residents had the right to be free from psychosocial abuse and neglect for five (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) of ten residents reviewed for abuse and neglect. The facility failed to:Ensure Resident #1 was free from verbal and emotional abuse by NA A on or around 05/30/25 and they failed to immediately suspend NA A (per their policy) as she had worked at the facility (26 shifts) since the incident. The facility did not investigate/report the incident because the DON stated Resident #1 later denied the allegation. Conduct thorough abuse/neglect investigations as they (staff) were photo-copying Abuse and Neglect in-services and changing the date without in servicing the staff for four separate self-reports, dated 06/14/25, 06/22/25, 06/26/25, and 07/02/25. Conduct thorough abuse/neglect investigations as they (staff) were photo-copying resident safe surveys for Residents #2, #3, #4, and #5 for two separate self-reports, dated 06/14/25 and 06/22/25. An Immediate Jeopardy (IJ) was identified on 07/09/25 at 3:24 PM and an IJ template was provided. While the IJ was removed on 07/10/25 at 5:00 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. These failures could place residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Resident #1 Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including morbid obesity, need for assistance with personal care, anxiety disorder, and age-related cognitive decline. Review of Resident #1's quarterly MDS assessment, dated 06/12/25, reflected a BIMS score of 15, indicating she was cognitively intact. Section GG (Functional Abilities) reflected she required substantial/maximal assistance for toileting hygiene. Review of Resident #1's quarterly care plan, dated 5/28/25, reflected she had an ADL self-care performance deficit with an intervention of requiring two staff participation to toilet. Resident #2 Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including mild cognitive impairment, muscle weakness, and a history of falling. Review of Resident #2's quarterly MDS assessment, dated 05/30/25, reflected a BIMS score of 14, indicating he was cognitively intact. Review of Resident #2's quarterly care plan, dated 05/27/25, reflected he had an ADL self-care performance deficit with an intervention of requiring two staff for assistance with bed mobility. During an interview on 07/09/25 at 10:08 AM, Resident #2 was shown a completed safe survey with his name on it. He stated he believed he had been asked those questions before, but if he had, it had only been one time. Resident #3 Review of Resident #3's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, mild cognitive impairment, anxiety disorder, and need for assistance with personal care. Review of Resident #3's quarterly MDS assessment, dated 05/01/25, reflected a BIMS score of 14, indicating he was cognitively intact. Review of Resident #3's quarterly care plan, dated 05/05/25, reflected he had an ADL self-care deficit with an intervention of requiring one staff for assistance with bed mobility. During an interview on 07/09/25 at 10:11 AM, Resident #3 was shown a completed safe survey with his name on it. He stated he had never been asked those questions before and had never seen the document. Resident #4 Review of Resident #4's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including anxiety disorder, acute respiratory failure, history of falling, and muscle weakness. Review of Resident #4's quarterly MDS, dated [DATE], reflected a BIMS score of 10, indicating a moderate cognitive impairment. Review of Resident #4's quarterly care plan, dated 03/04/25, reflected he had an ADL self-care performance deficit with an intervention of requiring one staff for assistance with bed mobility. Resident #5 Review of Resident #5's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including joint disorders, cerebral infraction (stroke), cognitive communication deficit, and muscle weakness. Review of Resident #5's quarterly MDS, dated [DATE], reflected a BIMS score of 15, indicating she was cognitively intact. Review of Resident #5's quarterly care plan, dated 07/08/25, reflected she had an ADL self-care performance deficit with an intervention of requiring one staff for assistance with bed mobility. Review of safe surveys, dated 06/25/25 and included in the facility's 3613 (facility investigation report), from a self-report, dated 06/14/25, reflected the following questions/answers documented by the SW for Residents #2, #3, #4, and #5: 1. Do you feel safe in the facility? Yes? 2. Do the staff treat you with respect? Yes? 3. Do you know what to do if you witness or</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and establish policies and procedures to investigate any such allegations for one (Resident #1) of ten residents reviewed for abuse and neglect. The facility failed to: - Follow their Abuse and Neglect policy after Resident #1 was verbally/emotionally abused by NA A on or around 05/30/25 by not investigating the incident, not suspending NA A, and not reporting it to the ADM which resulted in psychosocial harm for Resident #1. An Immediate Jeopardy (IJ) was identified on 07/09/25 at 3:24 PM and an IJ template was provided. While the IJ was removed on 07/10/25 at 5:00 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. These failures could place residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including morbid obesity, need for assistance with personal care, anxiety disorder, and age-related cognitive decline. Review of Resident #1's quarterly MDS assessment, dated 06/12/25, reflected a BIMS score of 15, indicating she was cognitively intact. Section GG (Functional Abilities) reflected she required substantial/maximal assistance for toileting hygiene. Review of Resident #1's quarterly care plan, dated 5/28/25, reflected she had an ADL self-care performance deficit with an intervention of requiring two staff participation to toilet. Review of CNA A's time sheets, from 05/30/25 - 07/09/25, reflected she had worked 26 shifts during that timeframe. During an interview on 07/09/25 at 9:41 AM, CNA B stated the management staff were lax when it came to abuse and neglect. She stated the residents were in a vulnerable state and it was not fair to them to not take abuse seriously. She stated a couple of days after she first started working at the facility, on approximately 05/30/25, she was in training and shadowing CNA C. She stated Resident #1 had said something about not getting changed by NA A and CNA C asked Resident #1 about the situation. She stated NA A was walking past the room and heard the conversation. She stated NA A she charged into the room and at the resident and yelled, Keep my mother f***** name out of your mother f***** mouth! She stated Resident #1 was shaking and was terrified. She stated she told NA A she needed to leave Resident #1's room and CNA C had to walk NA A out of the room. She stated she told CNA C to ensure that incident was reported to management as it was verbal abuse. She stated she continued to see NA A working and asked ADON E why nothing had been done and ADON E told her CNA C had changed her statement and stated she had walked NA A out of the room before she said anything to Resident #1. She stated she wrote a statement and had assumed it had gone to the DON and was self-reported to the state. She was told that the DON told ADON E that without two written statements confirming it had happened, they could not do anything about it. CNA B was shown the four in-services (that had her name and signature on them) and she stated, You can tell these are copies! Look at the signatures - they are all the same! She stated she had not worked on any of those four dates and had been out of town on vacation. She stated, None of these are real. During an interview on 07/09/25 at 10:01 AM, Resident #1 stated she remembered NA A was sometimes mean to her. She stated she remembered (her account from the incident on 05/30/25) NA A telling her she was so big and her butt was so big it was hard to change her. She stated she had made her feel humiliated, ashamed, and scared. She stated the DON told her NA A would not work with her anymore, but NA A continued to come and try to change her, and she would tell her no because she did not want her to provide care. She stated she did not believe NA A every got talked to by management. During an interview and observation on 07/09/25 at 11:50 AM, ADON E stated the ADM was the abuse and neglect coordinator. She stated she did not witness the incident regarding NA A and Resident #1 on 05/30/25 but was told about it by CNA B. She stated she reported it to the DON and the DON told her she found it to be unsubstantiated. She stated she would expect for the incident to have been reported the state if it had not been. She stated the DON told her she would not bring it to corporate's attention unless there were two witnesses confirming it happened. She stated when she initially interviewed CNA C, she confirmed the events of the incident that CNA B had relayed to her. She stated when she wrote her statement, she changed the story and wrote that she never heard anything. She stated she told CNA C to document the truth, but she would not. She stated both witness statements were given to the DON. She stated NA A was never suspended and continued to work on Resident #1's hall. During an interview on 07/09/25 at 12:24 PM the DON stated her expectations</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made for one (Resident #1) of ten residents reviewed for abuse. The facility failed to: - Ensure Resident #1 was free from verbal and emotional abuse by NA A on or around 05/30/25 and they failed to immediately suspend NA A (per their policy) as she had worked at the facility (26 shifts) since the incident. The facility did not investigate/report (to HHSC) the incident because the DON stated Resident #1 later denied the allegation. - Notify the Abuse and Neglect Coordinator (ADM) of the alleged abuse by NA A towards Resident #1 so it could be investigated and handled appropriately to ensure her safety. An Immediate Jeopardy (IJ) was identified on 07/09/25 at 3:24 PM and an IJ template was provided. While the IJ was removed on 07/10/25 at 5:00 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. These failures could place residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including morbid obesity, need for assistance with personal care, anxiety disorder, and age-related cognitive decline. Review of Resident #1's quarterly MDS assessment, dated 06/12/25, reflected a BIMS score of 15, indicating she was cognitively intact. Section GG (Functional Abilities) reflected she required substantial/maximal assistance for toileting hygiene. Review of Resident #1's quarterly care plan, dated 5/28/25, reflected she had an ADL self-care performance deficit with an intervention of requiring two staff participation to toilet. Review of the facility's self-reports to HHSC from 05/01/25 - 07/01/25, reflected no self-report regarding Resident #1 and NA A from 05/30/25. During an interview on 07/09/25 at 9:41 AM, CNA B stated the management staff were lax when it came to abuse and neglect. She stated the residents were in a vulnerable state and it was not fair to them to not take abuse seriously. She stated a couple of days after she first started working at the facility, on approximately 05/30/25, she was in training and shadowing CNA C. She stated Resident #1 had said something about not getting changed by NA A and CNA C asked Resident #1 about the situation. She stated NA A was walking past the room and heard the conversation. She stated NA A she charged into the room and at the resident and yelled, Keep my mother f***** name out of your mother f***** mouth! She stated Resident #1 was shaking and was terrified. She stated she told NA A she needed to leave Resident #1's room and CNA C had to walk NA A out of the room. She stated she told CNA C to ensure that incident was reported to management as it was verbal abuse. She stated she continued to see NA A working and asked ADON E why nothing had been done and ADON E told her CNA C had changed her statement and stated she had walked NA A out of the room before she said anything to Resident #1. She stated she wrote a statement and had assumed it had gone to the DON and was self-reported to the state. She was told that the DON told ADON E that without two written statements confirming it had happened, they could not do anything about it. CNA B was shown the four in-services (that had her name and signature on them) and she stated, You can tell these are copies! Look at the signatures - they are all the same! She stated she had not worked on any of those four dates and had been out of town on vacation. She stated, None of these are real. During an interview on 07/09/25 at 10:01 AM, Resident #1 stated she remembered NA A was sometimes mean to her. She stated she remembered (her recollection from the incident on 05/30/25) NA A telling her she was so big and her butt was so big it was hard to change her. She stated she had made her feel humiliated, ashamed, and scared. She stated the DON told her NA A would not work with her anymore, but NA A continued to come and try to change her, and she would tell her no because she did not want her to provide care. She stated she did not believe NA A every got talked to by management. During an interview on 07/09/25 at 11:50 AM, ADON E stated the ADM was the abuse and neglect coordinator. She stated she did not witness the incident regarding NA A and Resident #1 on 05/30/25 but was told about it by CNA B. She stated she reported it to the DON and the DON told her she found it to be unsubstantiated. She stated she would expect for the incident to have been reported the state if it had not been. She stated the DON told her she would not bring it to corporate's attention unless there were two witnesses confirming it happened. She stated when she initially interviewed CNA C, she confirmed the events of the incident that CNA B had relayed to her. She stated when she wrote her statement, she changed the story and wrote that she never heard anything. She stated she told CNA C to document the</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, and record reviews the facility failed to ensure in response to allegations of abuse, neglect, or mistreatment, have evidence that all alleged violations were thoroughly investigated and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for two of ten (Resident #6 and Resident #7) residents reviewed for Abuse and Neglect. The facility failed to thoroughly investigate and report within 5 working days, when Resident #6 reported her roommate, Resident #7, hit her and twisted her arm on 06/14/25. The Provider Investigation Report was due on 06/19/25 but was not submitted until 07/09/25 This failure could place residents at risk for abuse, neglect, and exploitation.</p> <p>Findings included:</p> <p>Resident #6</p> <p>Review of Resident #6's undated face sheet reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her primary diagnosis was unspecified dementia, moderate, without behavioral disturbance, mood disturbance, and anxiety. Secondary diagnoses included major depressive disorder, hypertension (high blood pressure), rheumatoid arthritis (chronic inflammation, usually in the joints causing pain and swelling but can affect the eyes, lungs, and heart), heart failure, and insomnia.</p> <p>Review of Resident #6's quarterly MDS assessment, dated 04/02/25, reflected a BIMS score of 11 which indicated moderately impaired cognition. The MDS reflected some feelings of isolation but no other mood or behavior symptoms. The MDS reflected no hallucinations or delusions.</p> <p>Review of Resident #6's comprehensive care plan, revised 02/11/25, reflected in part, "Focus &amp;dash; The resident has impaired cognitive function and impaired thought process due to dementia. Goal &amp;dash; The resident will be able to communicate basic needs on a daily basis through the next review date. Interventions &amp;dash; Administer meds as ordered. Communicate with the resident/family/caregivers regarding residents' capabilities and needs&amp;hellip;&amp;rdquo;</p> <p>Review of Resident #6's progress note written by LVN K, dated 06/14/25 at 11:51 AM, reflected, "This nurse was notified by (Resident #6) that her roommate (Resident #7) twisted her right arm while they were both in their room. Resident (#6) stated, (Resident #7) held my arm and twisted it and she was hitting my arm and now my arm is twitching. Assessed resident's arm, no bruising, no swelling, or redness noted. Resident rates right arm pain 4/10, PRN Tylenol 325mg x2=650mg admin. Resident able to move arm without any facial grimacing. VS 100/68, 77, 16, 98.4 97% on room air. Resident's room was changed to (number). On call NP (name) notified, received new order for X-ray to right arm and to call back with results. DON notified, administrator was notified by DON. RP (Name) Notified.&amp;rdquo; [sic]</p> <p>Resident #7</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #7's undated face sheet reflected an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted [DATE]. Her diagnoses included vascular dementia unspecified severity with agitation, unspecified fracture of right femur (large bone in the top of the leg), hypertension (high blood pressure), and diabetes.</p> <p>Review of Resident #7's quarterly MDS assessment, dated 06/26/25, reflected a BIMS score of 3 which indicated severely impaired cognition. The assessment reflected no inattention, no disorganized thinking, and no behavior symptoms.</p> <p>Review of Resident #7's comprehensive care plan, revised 04/02/25, reflected in part, "Focus &amp;dash; The resident has potential to demonstrate physical behaviors Dementia [sic]. Goal &amp;dash; The resident will not harm self or others through the review date. Interventions &amp;dash; Assess and address for contributing sensory deficits. Assess and anticipate resident's needs&amp;hellip; Communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation&amp;hellip;&amp;rdquo;</p> <p>Review of Resident #7's progress note written by LVN K, dated 06/14/25 at 2:44 PM, reflected, "this writer was notified by (Resident #6) that (Resident #7) twisted her right arm while hitting her. Resident (#7) stated, "I didn't do it, that's a lie." Resident is alert and confused, does not appear to be in distress or discomfort. Resident keeps following roommate everywhere she goes&amp;hellip; DON/Administrator notified, called RP (name) notified, NP notified by communication form&amp;hellip;&amp;rdquo;</p> <p>Review of the facility's self-report binder reflected the initial Self Reporting Template but no Provider Investigation Report &amp;dash; form 3613 -A.</p> <p>Review of the intake reporting system reflected the PIR was submitted on 07/09/25.</p> <p>During an interview on 07/08/25 at 3:06 PM, the Provider Investigation Report (PIR) was requested from the DON.</p> <p>During an interview on 07/09/25 at 12:23 PM, the DON stated for last 5 weeks, nursing had been investigating and completing the self-reports. Regarding the incident on 06/14/25 between Resident #6 and Resident #7, the DON stated she had reported and investigated the allegation. The DON stated she was told, "Resident #6 reported someone came in the room and hit her.&amp;rdquo; The DON stated she asked Resident #7 if anyone had been in the room and Resident #7 denied anyone else being in the room. The DON stated she was not aware that Resident #7 was the person accused of hitting Resident #6. The DON stated the SW was responsible for completing safe surveys. She stated it did not meet her expectations that the surveys were completed 11 days after the allegation was made. She stated the surveys should have been done the next practicable business day. The DON stated the Abuse Coordinator was responsible for investing and reporting.</p> <p>During an interview on 07/09/25 at 2:10 PM, the ADM stated she was the Abuse Coordinator. She stated the DON was not able to locate the Provider Investigation Report yesterday after the document was requested. The ADM stated she checked her email and did not find a copy of the report. The ADM stated she submitted a PIR report to HHSC on the evening of 07/08/25. She stated it was her expectation that every allegation was thoroughly investigated, safe surveys were conducted, and staff were in-serviced within the five-day period.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Abuse/Neglect policy, revised 05/09/17, reflected in part, "D. Identification. The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events"; F. Investigation. Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. 1. The administrator in consultation with Risk Management Department will be responsible for investigating and reporting cases to the HHSC; 3. 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. 6. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s); Resident to Resident. The above policy will apply to potential resident-to-resident abuse. Provider letter 17-18 will be reviewed to determine if resident-to-resident abuse occurred."</p>		