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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Care Center	121 Fm 971 Georgetown, TX 78626

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's mental and psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications), and need to alter treatment significantly for one (Resident #1) of eight residents reviewed for notification of changes. The facility failed to ensure LVN A notified the doctor, nurse practitioner, director of nursing and family when Resident #1 fell on [DATE]. The facility failed to ensure LVN C notified the doctor, nurse practitioner, director of nursing and family immediately when Resident #1 appeared withdrawn and had changes in behavior. An Immediate Jeopardy (IJ) was identified on 01/08/2026. The IJ template was provided to the facility on [DATE] at 5:30 PM. While the IJ was removed on 01/09/2026 at 6:00 PM, the facility remained out of compliance at a scope of isolated and severity level of no actual harm. This failure could place residents at risk of delayed identification of injuries, treatment, hospitalization and/or death. Findings included: Review of Resident #1's face sheet dated 01/08/2026 reflected a [AGE] year-old man admitted on [DATE] and readmitted on [DATE] with diagnoses of displaced intertrochanteric fracture of right femur (a severe break in the upper thigh bone), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness on right side of body caused by stroke), type 2 diabetes mellitus (condition where the body does not use insulin effectively or cannot produce enough insulin leading to high blood sugar levels), aphasia (language disorder often after stroke of brain injury that impairs speaking, understanding, reading or writing), muscle weakness, unspecified abnormalities of gait and mobility (difficulties with walking or movement where the specific cause is not identified), dysphagia (difficulty swallowing), cerebral infarction due to thrombosis of right anterior cerebral artery (type of store caused by a blood clot leading to brain tissue death) and unsteadiness on feet. Review of Resident #1's care plan reflected Resident #1 had hemiplegia/hemiparesis with revision date of 10/24/2025 with interventions to assist with ADLs/mobility as needed. Review reflected Resident #1 had an ADL self-care performance deficit and required assistance of one staff for toilet use, bathing, and dressing. Review reflected Resident #1's care plan dated 10/22/2025 reflected Resident #1 was at risk for falls, goal included Resident #1 would not sustain serious injury with interventions to be sure the resident's call light was within reach, educate resident about safety reminders, and reeducate Resident #1 to lock wheelchair brakes prior to transferring. Review of Resident #1's assessments reflected there were no neurological checks initiated or completed incident documentation for Resident #1's fall on 12/07/2026. Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 07 which indicated severe cognitive impairment. Review reflected Resident #1 utilized a wheelchair. Review of Resident #1's functional abilities reflected Resident #1 required set up assistance (help provider verbal cues and/or (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	had a fall and LVN C stated she was not aware of a fall. LVN C stated that the NP found Resident #1 had bruising and swelling to his right arm. LVN C stated she was upset with herself because she thought Resident #1 was depressed and did not observe the bruising. LVN C stated the protocol for falls was to go and assess the resident which included assessing the resident's skin, check range of motion, notify the NP, DON, ADON, and notify the family. LVN C stated then an incident report was completed with all of the information from the assessment and neurological checks were initiated. LVN C stated in the incident report, she documented what was seen, and document which family member that was notified and the NP name that was notified. LVN C stated neurological checks were initiated immediately for an unwitnessed fall because the resident may have hit their head and staff may be unaware and neurological checks help identify if there are any changes. LVN C stated it was important to complete the incident report so that the documentation was there and everyone was aware and extra eyes could be put on the resident and they could also be monitored. LVN C stated that monitoring would help catch any changes, identify a pattern and put extra precautions in place such as fall mat. LVN C stated staff thought Resident #1 was still mostly independent and that he needed more help. LVN C stated after a fall residents were monitored for at least 72 hours. LVN C stated rounds were conducted at least every 2 hours. LVN C stated that Resident had another fall on 12/13/2025 and she notified the NP and she ordered 2 tramadol a day for three days and would follow up when she returned the next week. LVN C stated that the NP told her to do an x-ray on Resident #1's shoulder and chest and the results returned that the shoulder was broken. LVN C stated the first x-rays were completed on Resident #1's elbow and knee on 12/12/2025. During an interview on 01/08/2025 at 11:42 AM, LVN D stated she usually worked on 500 hall. LVN D stated that she had just returned to work at the facility after being on leave. She stated that prior to going on leave Resident #1 was able to transfer himself from bed to wheelchair and to the toilet. LVN D stated that Resident #1 spent a lot of time up and went to the dining room for his meals. LVN D stated Resident #1 liked to sit at the window at the end of the hall and listen to music. LVN D stated that Resident #1 needed more help with transferring and toileting after she returned from leave. LVN D stated that when there was a fall the nurse immediately went to complete an assessment and then the ADON/DON, ADM, RP and NP were notified. LVN D stated if the resident was injured they would be sent to the hospital. If there is no injury, neurological checks would be started, and the nurse should ensure the fall was documented. LVN D stated there was a 72 hour monitoring period after a fall. LVN D stated an incident report should be completed after a fall which cued the neurological checks in PCC (charting system). The incident report also had a place to document who was notified of the fall, description of the fall and initial vitals. LVN D stated it was important to notify the MD or NP of a fall in case they wanted to send the resident to the hospital or if nothing looks physically wrong, they may have other orders or if the resident had started new medication they could see if there was a pattern. LVN D stated it was important to document a fall not only for the resident's health but if anything were to happen later such as a fracture and there was not anything documented the facility could have possibly known when it happened. LVN D stated documentation was also important for communication purposes so anyone could look at who was actually notified and communication can be consistent with everyone. During an interview on 01/08/2026 at 11:53 AM, RN E stated the fall protocol was to ensure the resident's safety, take vital signs, assess the resident, assist them back to bed, notify the provider, DON, family member and ADM. RN E stated if the fall was witnessed and they did not hit their head then neurological checks would not be initiated, but if they resident had an unwitnessed fall then neurological checks would initiated. RN E stated that a risk management note or incident report would be completed and that (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated he was unsure if interventions were documented on risk management. During an interview on 01/08/2025 at 3:27 PM, NP stated she saw Resident #1 on 12/12/2025 and noticed bruising on his arm. NP stated prior to this, a fall was never reported. NP stated she visited with Resident #1's roommate and noticed Resident #1 was withdrawn and sat in then wheelchair, turned the opposite direction which was out of the ordinary for Resident #1. The NP stated that when she looked at Resident #1 more closely, she noticed bruising. NP stated bruising was different colors, some part was green, some dark purple, some more fresh and looked like it had happened in the past couple of days. The NP stated it could have happened hours to a day or two before and there was no way to exactly tell. The NP stated when there is a fall, she expected the facility to reach out and she could usually see the resident within a few days or the next day or so. The NP stated she did not recall if she was notified about Resident #1's fall on 12/13/2025 and would have to review her notes. The NP stated she normally saw a resident post fall and believed she saw him not too long after. The NP stated that she and PT looked at Resident #1 more closely because he seemed more withdrawn and she ordered an x-ray of his collar bone because it looked swollen. NP stated from that x-ray a shoulder dislocation was noted and she sent him to the hospital, but the hospital did not see a dislocation only a leg fracture. During an interview on 01/08/2025 at 4:37 PM, LVN A stated that she worked at the facility for about 6 years. LVN A stated that she believed it was a weekend that she was informed by CNA B that Resident #1 was on the floor. LVN A stated CNA B translated for her and he stated he was in pain. LVN A stated that there was no injury and she took his vitals and completed an assessment. LVN A stated that she gave Resident #1 a PRN tramadol and monitored him. LVN A stated that Resident #1's fall was a night and denied that he had a fall on 12/08/2025 at 5:00 AM. LVN A stated that nurses were supposed to document time of the fall, vitals, pain assessment, visible injuries and notify the chain of command (DON/ADON, MD and family). LVN A stated she did a late document note and she should have done right away. LVN A stated there were no injuries at the time of the fall. LVN A stated that Resident #1 reported generalized pain and it was relieved by tramadol. LVN A stated neurological checks should have been initiated because it was an unwitnessed fall. LVN A stated documentation was supposed to be completed by the end of the shift for continuity of care. LVN A stated she did not notify the DON, NP or family because it was a long night, we were short staffed, and I was helping out on other halls that night. LVN A stated she did follow up with Resident #1 about his pain, and he did not have any. LVN A stated she let the oncoming nurse know that she provided Resident #1 with pain medication but did not notify the nurse of a fall. LVN A stated it was important to notify providers and clinical management team about a fall in the event of delayed injury and it could cause a delay in care for the resident. LVN A stated it was important to document so that the nurse could monitor for any type of change if the resident is not at their base line. LVN A stated she worked her next shift on 12/10/2025 and 12/11/2025 and noticed Resident #1 did not look out the window like he usually did after dinner. LVN A stated that Resident #1's routine after dinner was not the same and he went straight to bed instead of hanging out. LVN A stated she did not note that change in behavior on the 24 hour report to the oncoming nurse or anyone else. Review of undated facility policy titled Notifying the Physician of Change in Status reflected nurses will document time and call of physician and should contact the physician when an assessment deem it necessary for medical attention. Review of facility policy titled Fall Policy reflected falls resulting in serious injury will be reported to the DON or the ADM. Review reflected an in-service dated 12/30/2025 was conducted with staff over topic notifying the physician of change in status. Review reflected an in-service dated 12/30/2025 was conducted over topic completing the incident report with nursing staff and included instructions on how to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physically complete the incident report, but did not include when to complete the incident report. Review reflected there were no in-services completed on falls after Resident #1's fall on 12/07/2025 or 12/13/2025. Review of coaching form dated 12/12/2025 with LVN A reflected documentation of any fall / injury that was not completed as situation with specific coaching as all and injuries must be documented at the time of the incident with employee response as states understanding. Form was signed by the DON, but not LVN A and did not include coaching on notifications of change to the provider, the DON or the RP. Review of CNA 2-hour rounding sheets reflected routine rounding was completed with Resident #1 on 12/14/2025, 12/15/2025, and 12/16/2025 with no indication of increased rounding following 2 falls. Review of documentation that included staff knowledge check on abuse and neglect reflected 16 documents that were undated and/or did not include information on which staff completed the check. The knowledge check did not include information about falls or reporting change of condition. The ADM, the DON, and RNC were notified on 01/08/2026 at 5:30 PM, that an IJ had been identified. An IJ template was provided and a POR was requested. The following POR was approved on 01/09/2026 at 11:38 AM and indicated: Plan of Removal F580On 01/08/2026 an abbreviated survey was initiated at the facility. On 01/08/2026 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. Problem: The facility failed to immediately consult the resident's physician when there is, an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); Interventions: Immediate in-service training for all licensed nursing staff including PRN, Agency and new staff will be conducted by the DON and Administrator on 1.8.2026. DON and Administrator were in-serviced prior to by Regional Compliance Nurse. Training will focus on the facility's Notification of Physician Change in Condition policy, emphasizing mandatory immediate reporting of any resident falls or significant changes in condition to the physician and DON, including documentation requirements and timelines. Facility Administrator and DON in-serviced on Risk Management protocol by Area Director of Operations and Regional Compliance Nurse. 1.8.2026A revised notification protocol will be implemented requiring the nurse discovering or responding to a fall to: a) Conduct an immediate assessment of the resident; b) Notify the DON and treating physician or N[TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure residents' environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of eight residents reviewed for accidents and hazards.The facility failed to ensure Resident #1 was monitored after a fall on 12/07/2025 which resulted in a subsequent fall on 12/13/2026 and femur fracture.The facility failed to ensure new interventions were put into place after Resident #1's 12/07/2025 fall was reported to the DON on 12/12/2025 to prevent a second fall on 12/13/2025.The facility failed to ensure new interventions were not delayed and put into place immediately after Resident #1's fall on 12/13/2025.An Immediate Jeopardy (IJ) was identified on 01/08/2026. The IJ template was provided to the facility on [DATE] at 5:30 PM. While the IJ was removed on 01/09/2026 at 6:000 PM, the facility remained out of compliance at a scope of isolated and severity level of no actual harm. This failure could place residents at risk of delayed identification of injuries, treatment, hospitalization and/or death.Findings included: Review of Resident #1's face sheet dated 01/08/2026 reflected a [AGE] year-old man admitted on [DATE] and readmitted on [DATE] with diagnoses of displaced intertrochanteric fracture of right femur (a severe break in the upper thigh bone), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness on right side of body caused by stroke), type 2 diabetes mellitus (condition where the body does not use insulin effectively or cannot produce enough insulin leading to high blood sugar levels), aphasia (language disorder often after stroke of brain injury that impairs speaking, understanding, reading or writing), muscle weakness, unspecified abnormalities of gait and mobility (difficulties with walking or movement where the specific cause is not identified), dysphagia (difficulty swallowing), cerebral infarction due to thrombosis of right anterior cerebral artery (type of store caused by a blood clot leading to brain tissue death) and unsteadiness on feet. Review of Resident #1's care plan reflected Resident #1 had hemiplegia/hemiparesis with revision date of 10/24/2025 with interventions to assist with ADLs/mobility as needed. Review reflected Resident #1 had an ADL self-care performance deficit and required assistance of one staff for toilet use, bathing, and dressing. Review reflected Resident #1's care plan dated 10/22/2025 reflected Resident #1 was at risk for falls, goal included Resident #1 would not sustain serious injury with interventions to be sure the resident's call light was within reach, educate resident about safety reminders, and reeducate Resident #1 to lock wheelchair brakes prior to transferring. Review of Resident #1's assessments reflected there were no neurological checks initiated or completed incident documentation for Resident #1's fall on 12/07/2026. Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 07 which indicated severe cognitive impairment. Review reflected Resident #1 utilized a wheelchair. Review of Resident #1's functional abilities reflected Resident #1 required set up assistance (help provider verbal cues and/or touching/steadying as resident completes activity) for chair/bed-to-chair transfers, toilet transfers, going from sitting to standing and going from lying to sitting on the edge of the bed. Review reflected Resident #1 required supervision or touching assistances (helper providers verbal cues and/or touching/steadying and/or contact guard as resident completed activity) when walking 10 feet to 50 feet. Review reflected Resident #1 was occasionally incontinent of bladder and always continent of bowel. Review reflected Resident #1 had no falls since admission. Review of Resident #1 quarterly MDS dated [DATE] reflected a BIMS of 8 which indicated moderate cognitive impairment. Review reflected Resident #1 required partial/moderate assistance (helper does less than half the effort, helper listens, holds or supports trunk of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	socket in the shoulder blade). Review of emergency room diagnostic radiology report dated 12/17/2025 reflected x-ray of shoulder reflected no acute fractures or dislocations. Review reflected Resident #1 was found to have a nondisplaced fracture of the greater trochanter of the right proximal femur (break in upper thigh bone near the hip). Operation included a right hip intramedullary nail. During an interview on 01/08/2026 at 9:51 AM, CNA B stated she worked at the facility for thirteen years. CNA B stated that she usually worked the night shift from 7:00 pm to 7:00 am. CNA B stated she usually worked on the 500 hall, and she was familiar with Resident #1. CNA B stated that at the beginning of December 2025 she recalled Resident #1 had a fall. CNA B stated that she answered Resident #1's call light and found him on the floor. CNA B stated that Resident #1 appeared to have fallen as he tried to transfer to his wheelchair. CNA B stated that Resident #1 faced his bed and that his feet were under his bed. CNA B stated she called LVN A, and they assisted Resident #1 to his wheelchair. CNA B stated that Resident complained of pain and pointed to his chest, but had difficult speaking. CNA B stated that she did not see any bruising on Resident #1 at that time. CNA B stated that she did not stay after she assisted LVN A with helping Resident #1 into his wheelchair. CNA B stated LVN A gave Resident #1 pain medication and then they assisted Resident #1 into bed. CNA B stated that Resident #1 had an arm and leg on one side of his body that did not function well, but she could not recall which side it was. CNA B stated that she checked on Resident #1 a few times that night and he did not have any signs of pain after he was put into bed. CNA B stated she did not recall the time of the fall. CNA B stated she was then off for a few days and when she returned, she saw that Resident #1 had bruising. CNA B stated she was off for at least three days. CNA B stated since the fall Resident #1 was now total assistance and incontinent. CNA B stated that prior to the fall Resident #1 was able to transfer himself and used a pull-up and not a brief. CNA B before the fall, Resident #1 was a 1 person transfer and required limited assistance. CNA B stated Resident #1 was able to bear weight and assisted by holding the back of his pants and he was able to pivot himself during transfers. CNA B stated after the fall, staff then had to do most of the work. CNA B stated that fall protocol was to ensure the resident was okay, stay with the resident and call the nurse. CNA B stated it was sometimes difficult to understand Resident #1 because he had a difficult time speaking. During an interview on 01/08/2026 at 10:11 AM, LVN C stated she usually worked 6:00 am to 6:00 pm. LVN C stated she usually worked 500 hall and was familiar with Resident #1. LVN C stated that at the beginning of December 2025 she noticed Resident #1 behaved differently and had not been getting out of bed. She stated Resident #1 did not want to go to the dining room. LVN C stated she thought Resident #1 was depressed because he thought he may have been discharging home. LVN C stated she did not think Resident #1 seemed like himself because he did not want to go to the dining room or come out of his room as often. LVN C stated that he was sometimes late to dinner because he ambulated around the facility or sat at the end of the hall and listened to music while he looked out the window. LVN C stated that the NP talked with Resident #1 and he stated he was in pain. LVN C stated the NP asked if Resident #1 had a fall and LVN C stated she was not aware of a fall. LVN C stated that the NP found Resident #1 had bruising and swelling to his right arm. LVN C stated she was upset with herself because she thought Resident #1 was depressed and did not observe the bruising. LVN C stated the protocol for falls was to go and assess the resident which included assessing the resident's skin, check range of motion, notify the NP, DON, ADON, and notify the family. LVN C stated then an incident report was completed with all of the information from the assessment and neurological checks were initiated. LVN C stated in the incident report, she documented what was seen, and document which family member that was notified and the NP name that was notified. LVN C stated neurological checks were initiated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately for an unwitnessed fall because the resident may have hit their head and staff may be unaware and neurological checks help identify if there are any changes. LVN C stated it was important to complete the incident report so that the documentation was there and everyone was aware and extra eyes could be put on the resident and they could also be monitored. LVN C stated that monitoring would help catch any changes, identify a pattern and put extra precautions in place such as fall mat. LVN C stated staff thought Resident #1 was still mostly independent and that he needed more help. LVN C stated after a fall residents were monitored for at least 72 hours. LVN C stated rounds were conducted at least every 2 hours. LVN C stated that Resident had another fall on 12/13/2025 and she notified the NP and she ordered 2 tramadol a day for three days and would follow up when she returned the next week. LVN C stated that the NP told her to do an x-ray on Resident #1's shoulder and chest and the results returned that the shoulder was broken. LVN C stated the first x-rays were completed on Resident #1's elbow and knee on 12/12/2025. During an interview on 01/08/2025 at 11:42 AM, LVN D stated she usually worked on 500 hall. LVN D stated that she had just returned to work at the facility after being on leave. She stated that prior to going on leave Resident #1 was able to transfer himself from bed to wheelchair and to the toilet. LVN D stated that Resident #1 spent a lot of time up and went to the dining room for his meals. LVN D stated Resident #1 liked to sit at the window at the end of the hall and listen to music. LVN D stated that Resident #1 needed more help with transferring and toileting after she returned from leave. LVN D stated that when there was a fall the nurse immediately went to complete an assessment and then the ADON/DON, ADM, RP and NP were notified. LVN D stated if the resident was injured they would be sent to the hospital. If there is no injury, neurological checks would be started, and the nurse should ensure the fall was documented. LVN D stated there was a 72 hour monitoring period after a fall. LVN D stated an incident report should be completed after a fall which cued the neurological checks in PCC (charting system). The incident report also had a place to document who was notified of the fall, description of the fall and initial vitals. LVN D stated it was important to notify the MD or NP of a fall in case they wanted to send the resident to the hospital or if nothing looks physically wrong, they may have other orders or if the resident had started new medication they could see if there was a pattern. LVN D stated it was important to document a fall not only for the resident's health but if anything were to happen later such as a fracture and there was not anything documented the facility could have possibly known when it happened. LVN D stated documentation was also important for communication purposes so anyone could look at who was actually notified and communication can be consistent with everyone. During an interview on 01/08/2026 at 11:53 AM, RN E stated the fall protocol was to ensure the resident's safety, take vital signs, assess the resident, assist them back to bed, notify the provider, DON, family member and ADM. RN E stated if the fall was witnessed and they did not hit their head then neurological checks would not be initiated, but if they resident had an unwitnessed fall then neurological checks would initiated. RN E stated that a risk management note or incident report would be completed and that would trigger other assessments such as the neurological checks, notification to the family, DON and provider. RN E stated that it was important to document falls to assess barriers and safety issues that may have been able to be prevented. RN E stated it was also important to document to monitor for changes, and prevent another fall happening again. RN E stated that it was important to notify the provider of a fall for any new orders or change in the resident as the provider was responsible for the resident's safety as well. During an interview on 01/08/2026 at 12:03 PM, DOR stated that if a resident had a fall and were not already working with therapy a screening would be completed to determine if they needed to be on therapy services and to look at what interventions could be done (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	depending on each resident. The DON stated ideally interventions would be put into place within the same week. The DON stated that Resident #1's level of assistance was that he was independent and needed some assistance that required help. The DON stated that Resident #1 sat in his wheelchair at the end of the hall and stood up himself when he grabbed the hand rail and predominately did things independently. The DON stated that Resident #1 now required more supervision than he previously required. The DON stated that the facility tried to have the same staff work on the same hall for continuity of care. The DON stated unfortunately Resident #1's right arm is flaccid and he kept it close to his body and the bruising wasn't found until 12/12/2025. The DON stated there were no increased complaints of pain. The DON stated a counseling was done with LVN A via phone that LVN A needed to document falls in a timely manner, notify all parties, complete a skin and pain assessment and address injuries immediately. The DON stated staff were supposed to finish documentation prior to ending their shift at the latest but ideally staff would document in real time. During an interview on 01/08/2025 at 3:02 PM, the ADM stated that the DON should be notified of a fall as soon as safely possible. The ADM stated that he expected that the fall be documented, the DON be notified and an incident report be completed. The ADM stated that it was important a fall was documented because it notified clinical leadership and allowed the team to take action and put interventions into place. The ADM stated it was also important the provider was notified of a fall. The ADM stated that when a fall occurred it was expected that the nurse notify the DON, the fall would be then brought into the morning clinical meeting and discussed to ensure appropriate steps have been taken. The ADM stated ideally it was discussed the following day if not the same day, to discuss interventions and root cause of the fall. The ADM stated the nurses had to notify the physician and responsible parties. The ADM stated the interventions should be put into place pretty soon after a fall and there was no specific timeframe. The ADM stated it did not meet his expectations that fall interventions were not put into place until 12/12/2025 after a fall on 12/07/2025. The ADM stated he became aware of Resident #1's fall the same time as the DON and believed it was on 12/12/2025. The ADM stated that he thought Resident #1's fall was on 12/08/2025 not 12/07/2025. The ADM stated he was not sure why LVN A documented a fall on 12/07/2025 and believed it was an error. The ADM stated he was unsure why LVN A documented a fall on 12/17/2025 if it happened on 12/07/2025. The ADM stated the DON provided counseling to LVN A. The ADM stated that he expected documentation to be completed on the same shift prior to leaving. The ADM stated he did not have interventions for Resident #1's 12/13/2025 fall memorized. The ADM stated that it was tricky to interview Resident #1 because he had intense dysphagia. The ADM stated that when he interviewed Resident #1, Resident #1 indicated that he knew he needed to use his call light and stated Resident #1 did not like to use his call like or got impatient. The ADM stated fall interventions would be documented in the care plan and would be dated 12/13/2025 or later. The ADM stated he was unsure if interventions were documented on risk management. During an interview on 01/08/2025 at 3:27 PM, NP stated she saw Resident #1 on 12/12/2025 and noticed bruising on his arm. NP stated prior to this, a fall was never reported. NP stated she visited with Resident #1's roommate and noticed Resident #1 was withdrawn and sat in then wheelchair, turned the opposite direction which was out of the ordinary for Resident #1. The NP stated that when she looked at Resident #1 more closely, she noticed bruising. NP stated bruising was different colors, some part was green, some dark purple, some more fresh and looked like it had happened in the past couple of days. The NP stated it could have happened hours to a day or two before and there was no way to exactly tell. The NP stated when there is a fall, she expected the facility to reach out and she could usually see the resident within a few days or the next day or so. The NP stated she did not recall if she was notified about (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Care Center	121 Fm 971 Georgetown, TX 78626

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's fall on 12/13/2025 and would have to review her notes. The NP stated she normally saw a resident post fall and believed she saw him not too long after. The NP stated that she and PT looked at Resident #1 more closely because he seemed more withdrawn and she ordered an x-ray of his collar bone because it looked swollen. NP stated from that x-ray a shoulder dislocation was noted and she sent him to the hospital, but the hospital did not see a dislocation only a leg fracture. During an interview on 01/08/2025 at 4:37 PM, LVN A stated that she worked at the facility for about 6 years. LVN A stated that she believed it was a weekend that she was informed by CNA B that Resident #1 was on the floor. LVN A stated CNA B translated for her and he stated he was in pain. LVN A stated that there was no injury and she took his vitals and completed an assessment. LVN A stated that she gave Resident #1 a PRN tramadol and monitored him. LVN A stated that Resident #1's fall was a night and denied that he had a fall on 12/08/2025 at 5:00 AM. LVN A stated that nurses were supposed to document time of the fall, vitals, pain assessment, visible injuries and notify the chain of command (DON/ADON, MD and family). LVN A stated she did a late document note and she should have done right away. LVN A stated there were no injuries at the time of the fall. LVN A stated that Resident #1 reported generalized pain and it was relieved by tramadol. LVN A stated neurological checks should have been initiated because it was an unwitnessed fall. LVN A stated documentation was supposed to be completed by the end of the shift for continuity of care. LVN A stated she did not notify the DON, NP or family because it was a long night, we were short staffed, and I was helping out on other halls that night. LVN A stated she did follow up with Resident #1 about his pain, and he did not have any. LVN A stated she let the oncoming nurse know that she provided Resident #1 with pain medication but did not notify the nurse of a fall. LVN A stated it was important to notify providers and clinical management team about a fall in the event of delayed injury and it could cause a delay in care for the resident. LVN A stated it was important to document so that the nurse could monitor for any type of change if the resident is not at their base line. LVN A stated she worked her next shift on 12/10/2025 and 12/11/2025 and noticed Resident #1 did not look out the window like he usually did after dinner. LVN A stated that Resident #1's routine after dinner was not the same and he went straight to bed instead of hanging out. LVN A stated she did not note that change in behavior on the 24 hour report to the oncoming nurse or anyone else. Review of undated facility policy titled Notifying the Physician of Change in Status reflected nurses will document time and call of physician and should contact the physician when an assessment deem it necessary for medical attention. Review of facility policy titled Fall Policy reflected falls resulting in serious injury will be reported to the DON or the ADM. Review reflected there were no in-services completed on falls after Resident #1's fall on 12/07/2025 or 12/13/2025. Review reflected there were no in-services on 01/08/2026 training staff on new fall prevention interventions or increased rounding for Resident #1. Review of coaching form dated 12/12/2025 with LVN A reflected documentation of any fall / injury that was not completed as situation with specific coaching as alls and injuries must be documented at the time of the incident with employee response as states understanding. Form was signed by the DON, but not LVN A and did not include coaching on notifications of change to the provider, the DON or the RP. Review of CNA 2-hour rounding sheets reflected routine rounding was completed with Resident #1 on 12/14/2025, 12/15/2025, and 12/16/2025 with no indication of increased rounding following 2 falls. Review of documentation that included staff knowledge check on abuse and neglect reflected 16 documents that were undated and/or did not include information on which staff completed the check. The knowledge check did not include information about falls or reporting change of condition. The ADM, the DON, and RNC were notified on 01/08/2026 at 5:30 PM, that an IJ had been identified. An IJ template was provided and a POR (continued on next page)

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