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	03/05/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for five of ten residents (Resident #1, Resident #34, Resident #42, Resident #51, and Resident #72) reviewed for ADLs. The facility failed to ensure Resident #1, Resident #34, Resident #42, Resident #51, and Resident #72 fingernails were trimmed and maintained. This failure could place residents at risk of not receiving care services, diminished quality of life, and decreased self-esteem.1.Record review of Resident #1's face sheet dated 3/05/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of metabolic encephalopathy, altered mental status, type 2 diabetes (uncontrolled blood sugar), vascular dementia (reduced blood flow to the brain), depression, pain in left wrist, traumatic subdural hemorrhage (bleeding inside the head) with loss of consciousness, cognitive communication deficit (difficulty communicating) cerebral infarction (stroke), hemiplegia and hemiparesis (one-side paralysis) following cerebral infarction affecting left non-dominant side, and need for assistance with personal care. Record review of Resident #1's MDS assessment dated [DATE] reflected that she had a BIMS score of 6, indicating moderately impaired cognition. Record review of Resident #1's care plan last reviewed on 1/23/2026 reflected that she required assistance with ADLs and staff were to check Resident #1's nail length, trim, and clean on bath days or as needed.Record review of Resident #1's POC response history for personal hygiene dated 3/05/2026 reflected that she received assistance every day from 2/04/2026-3/04/2026. The response history did not specify whether nail care was provided.During an interview and observation on 3/04/2026 at 9:52 a.m., Resident #1 was observed lying in bed and her fingernails were observed to have about 3-4 mm past edge of the fingertip. Resident #1 stated she did not like her fingernails long like that and asked, what can I do? Resident #1 stated that her family member trimmed her fingernails and she had not asked staff to.During an interview and observation on 3/05/2026 at 10:02 a.m., CNA A observed Resident #1's fingernails and then he stated they needed to be cleaned and they definitely need to be trimmed for sure. Resident #1's left hand was observed to be slightly contracted. CNA A stated that nail care happened as needed. CNA A said that the AD used to do nail care for some residents but not all of them-CNA A stated that at first, CNAs were not doing nail care.2.Record review of Resident #34's face sheet dated 3/05/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of cerebral infarction due to embolism of left middle cerebral artery, type 2 diabetes (uncontrolled blood sugar), Parkinson's disease (progressive neurological disorder), unspecified protein-calorie malnutrition, contracture in right hand, weakness, aphasia (language disorder) following cerebral infarction (stroke), muscle wasting and atrophy (muscle loss), cognitive communication deficit (difficulty communicating), and need for assistance with personal care. Record review of Resident #34's MDS assessment dated [DATE] reflected that she had a BIMS score of 00, which indicated severely impaired cognition. Record review of Resident #34's care plan last reviewed on 3/04/2026 reflected that she had an ADL self-care performance deficit and required a one-person assist for bathing.Record review of Resident #34's POC response history for personal hygiene dated 3/05/2026 reflected that she received assistance every day from 2/04/2026-3/04/2026. The (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	response history did not specify whether nail care was provided.During an observation and interview on 3/03/2026 at 1:34 p.m., Resident #34 was observed at the front of the building sitting in a geri chair and both of her hands appeared contracted with the right hand being the most contracted. Resident #34's fingernails were observed to be about 3 mm past edge of the fingertip. Resident #34 was non-interviewable and could not provide an opinion on her nails. During an observation and interview on 3/05/2026 at 9:22 a.m., LVN B observed Resident #34's fingernails and said they were a little long and they needed to be cleaned. Resident #34's hand was observed to be contracted and Resident #34's right hand fingernails were observed to have a dark unidentifiable substance underneath them resembling unclean fingernails. LVN B stated that CNAs and LVN did nailcare. LVN B stated that with the contracture, Resident #34 could scratch herself and it could get infected. 3.Record review of Resident #42's Face Sheet, dated 03/04/2026, reflected an [AGE] year-old male, admitted [DATE] with diagnoses that included cognitive communication deficit (a condition that affects how individuals think and communicate), muscle weakness (is decreased muscle strength), need for assistance with personal care (requires help with ADL's), diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired), chronic diastolic heart failure (leading to impaired heart function and various symptoms), lack of coordination (refers to difficulty in controlling voluntary movements, resulting in clumsy, unsteady, or awkward motions), and major depression (is a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems).Record review of Resident #42's quarterly MDS dated [DATE], reflected a BIMS Score of 4, which cognitively impaired.Record review of Resident #42's Care Plan, dated 01/13/2026, reflected Resident #42 required assistance and supervision with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #42 to maintain current level of function with assistance in his ADL care needs.Record review of Resident #42's ADL personal hygiene dated 03/05/2026 reflected to be provided during every shift. There was no fingernail ADL documentation for fingernail trimming from 02/04/2026 to 03/05/2026 in the ADL tasks checklist. Record review of nursing progress notes file for Resident #42 dated 03/05/2026 reflected no documentation that Resident #42 received ADL nail care services for fingernail trimming in the months of 12/3/2025 to 03/05/2026. During an interview on 03/03/2026 at 10:45 a.m. with Resident #42, he stated he does not like his fingernails long. Resident #42 stated that staff have not come around to trim his fingernails or offer to have them trimmed. Resident #42 does not know how long it's been, but his fingernails are too long. During an observation on 03/03/2026 at 10:47 a.m. of Resident #42 revealed the resident had untrimmed long fingernails, approximately one-inch-long from the fingernail bed on both his left and right hand.During an observation on 03/04/2026 at 10:00 a.m. of Resident #42 revealed the resident was peacefully sleeping. Resident #42 was observed to still have approximately one-inch-long fingernails that appeared to not be trimmed. During an interview on 03/04/2026 at 10:46 a.m. with ADM, he stated that the Resident #42 long fingernails will be addressed immediately. ADM stated he will have nursing staff take care of trimming Resident #42 fingernails.4.Record review of Resident #51's face sheet dated 3/05/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of Parkinson's disease (progressive neurological disorder), cognitive communication deficit (difficulty communicating), weakness, need for assistance with personal care, and muscle wasting and atrophy (muscle loss).Record review of Resident #51's MDS assessment dated [DATE] reflected that he had a BIMS score of 15, which reflected no cognitive impairment.Record review of Resident #51's care plan last reviewed on 3/01/2026 reflected that he had an ADL self-care performance deficit related to musculoskeletal impairment and required a one-person assist with bathing. Record review of Resident #51's POC response history for personal hygiene dated 3/05/2026 reflected that he received assistance every day from 2/04/2026-3/04/2026 except for on 2/12/2026 and 2/22/2026. The response history did not specify whether nail care was provided.During an observation and interview on 3/04/2026 at 10:18 a.m., Resident #51 was observed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lying in bed with his feet crossed. Resident #51's fingernails were observed to have about 3 mm past edge of the fingertip and he stated that staff had offered to trim his toenails, but not his fingernails. During an observation and interview on 3/05/2026 at 9:28 a.m., Resident #51 was observed in bed and his fingernails appeared to be the same length as they were on 3/04/2026. CNA H stated that Resident #51's nails looked clean but like they needed to be trimmed. 5.Record review of Resident #72's face sheet dated 3/05/2026 reflected a [AGE] year old male admitted on [DATE] with diagnoses of cerebral infarction (stroke), type 2 diabetes (uncontrolled blood sugar), vascular dementia, hemiplegia and hemiparesis (one-side paralysis) following unspecified cerebrovascular disease (condition that affects blood flow to the brain) affecting left non-dominant side and right dominant side, schizophrenia (brain disorder), cognitive communication deficit (difficulty communicating), weakness, unspecified abnormalities of gait and mobility, and need for assistance with personal care. Record review of Resident #72's MDS assessment dated [DATE] reflected that he had a BIMS score of 14, which indicated he had minimally impaired cognition.Record review of Resident #72's care plan last reviewed on 1/12/2026 reflected that he had an ADL self-care performance deficit and staff were to check his nail length and trim on bath days and as necessary.Record review of Resident #72's POC response history for personal hygiene dated 3/05/2026 reflected that he received assistance every day from 2/04/2026-3/04/2026. The response history did not specify whether nail care was provided.During an observation and interview on 3/04/2026 at 10:12 a.m., Resident #72 was observed sitting in a wheelchair in his room. Resident #72's fingernails were observed to have about 4 mm of past edge of the fingertip and there was a dark unidentifiable substance underneath them. Resident #72 said they just kind of grew out and said it had been a couple of weeks since had his nails cut. During an interview and observation on 3/04/2026 at 9:22 a.m., LVN B observed Resident #34's fingernails. Resident #34 was observed lying in bed and her right hand appeared contracted. LVN B stated that Resident #34's nails were long and needed to be cleaned. LVN B stated that CNAs trimmed residents' fingernails if they were not diabetic. LVN B stated she was familiar with Resident #34 but she had not trimmed her nails before. LVN B said she had not trimmed Resident #72's or Resident #51's nails and she did not know whether they were diabetic. During an interview on 3/05/2026 at 12:11 p.m., the AD stated that she used to work as a CNA and she was familiar with the facility's policy on nail care. The AD stated that CNAs did not do showers on Sundays, so they had more time to do nail care. The AD said that CNAs were supposed to check nails during every shower and that it was a part of their shower check list. The AD said that it was everyone's responsibility to do nail care and that she did manicures as an activity with around 10 residents per month. The AD stated that she did not recall doing Resident #1's nails and she could not recall the last time she trimmed Resident #34's nails. The AD said she did Resident #51's nails the last week of November (2025) or the first week of December (2025) and she said she had done Resident #72's nails twice since he was admitted -the AD said Resident #72's nails grew fast and the last time she trimmed them was 7 weeks ago. During an interview on 03/05/2026 at 12:30 p.m. with CNA A, he stated he worked at the facility for 10 months. The CNA A stated he received training on ADL care and trimming residents' fingernails. CNA A stated he has not performed any ADL fingernail trimmings for any residents since working here, but if he sees fingernails needing to be trimmed, he will ask the resident or tell a nurse. CNA A stated this goes for all residents as he works on all halls at the facility. CNA A stated training on ADL care and trimming residents' fingernails went over residents' fingernails need to be trimmed, sanded down, and cleaned as needed. CNA A stated residents' fingernails should be trimmed and cleaned. CNA A stated the facility verbally went over fingernail and nail care today. CNA A stated if resident's fingernails were not trimmed, it will be a concern since a resident can break a fingernail and prevent them from doing tasks, hurt themselves, or cause an infection. CNA A stated ADL care and trimming residents' fingernails are monitored by the nurses, but he is not entirely sure. CNA A stated that residents that are diagnosed as diabetic get nail care services from nurses only. CNA A stated he has received complaints from residents that staff (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were not providing nail care in which he stated to the residents that he would let a nurse or the DON know. CNA A stated it's the responsibility of all nursing staff to ensure ADL care and trimming residents' fingernails was taking place. CNA A stated if ADL care and trimming a resident's fingernails was not taking place, it could affect and diminish the resident's quality of life and potentially affect the resident's self-esteem, making the resident feel as if the facility staff do not care, and cause bacteria fungal. CNA A stated it's ultimately the overall responsibility of the DON to ensure ADL care and residents' fingernails were trimmed timely for all residents. During an interview on 03/05/2026 at 1:40 p.m. with LVN B, she stated she worked at the facility for 9 months. LVN B stated she received ADL care and trimming resident's fingernails timely training. LVN B stated ADL care and trimming resident's fingernails timely training goes over mindfulness of residents nails being maintained, trimmed, and to help with infection control. LVN B stated she does not remember the last time she received ADL fingernail care training besides verbally today. LVN B stated it's the responsibility of the CNAs and nursing staff to make sure residents' fingernails were trimmed and cleaned. LVN B stated ADL care and trimming resident's fingernails timely were monitored by the nursing staff. LVN B stated it's the responsibility of the LVN and nursing staff to ensure ADL care and trimming resident's fingernails was taking place for residents as residents can potentially scratch themselves cause an infection. LVN B stated if ADL care and not trimming resident's fingernails was not taking place, it could affect and diminish the resident's quality of life by the resident's potentially developing an infection in which may lead to many things like issues or be neglectful. LVN B stated it's ultimately the overall responsibility of the DON to check and ensure ADL care and resident's fingernails are trimmed for the residents at the facility.During an interview on 03/05/2026 at 3:39 p.m. with the DON, she stated she worked at the facility since 11/17/2025. The DON stated she received training on ADL care and trimming for residents' fingernails, she has provided that training to most staff. The DON stated that training on ADL care and trimming residents' fingernails for the nursing staff went over CNAs and nurses are to perform nail care, preventing residents from discomfort or pain with their fingernails not being trimmed, and residents have the right to have longer fingernails if they choose too. The DON stated ADL care and trimming of residents' fingernails were monitored by all nursing staff and any staff member, it's a group effort. The DON stated she had not received complaints from residents that staff were not trimming their fingernails. The DON stated if ADL care and trimming residents' fingernails was not taking place, it could affect and diminish the residents' quality of life as it could cause bacterial infection, injuries to the resident's skin, and effect the resident's dignity. The DON stated it's the responsibility of the DON to ensure ADL care and trimming residents' fingernails was taking place including the nursing department. The DON stated it's ultimately the overall responsibility of the DON to make sure residents are getting ADL care services for their fingernails. During an interview on 03/05/2026 at 4:00 p.m. with the ADM, he stated he worked at the facility since 12/01/2025. The ADM stated he was not trained on ADL care and trimming residents' fingernails as that was not in his scope as an ADM, and his nursing staff has received training for ADL care and fingernail trimming. The ADM stated that ADL care with trimming fingernails was the responsibility of CNAs and nursing staff. The ADM stated ADL care and trimming residents' fingernails were monitored by the CNAs and nursing staff. The ADM stated he had not received complaints from residents that staff were not trimming fingernails. The ADM stated it's the responsibility of the DON to ensure ADL care and trimming residents' fingernails was taking place. ADM stated the AD can assist with providing fingernail care, but it was not the AD's responsibility. The ADM stated if ADL care and trimming residents' fingernails was not taking place, it could affect and diminish the residents' quality of life by potentially scratching or hurt themselves if the residents fingernails get too long. The ADM stated it's ultimately the overall responsibility of the DON to ensure ADL care and residents' fingernails were trimmed for all residents. The ADM stated it's his expectation for ADL care and fingernails being trimmed is taking place for all residents by the nursing staff. Record review of facility in-service education for ADL documentation dated 10/21/2025 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected to have been provided and completed by nursing staff including LVN B, but not completed by AD, CNA A, or CNA H. Record review of ADL Nail Care policy with no date reflected Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticles are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is common. Nail care, especially trimming, is performed by a podiatrist in those with diabetes and peripheral vascular disease. Goals: Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation.The facility failed to date all items after they were opened. The facility failed to properly label and date all items in the refrigerator.The facility failed to ensure all items in the dry storage room were properly sealed after being opened.The facility failed to maintain clean cooking equipment.The facility failed to keep the garbage can closed when not in use.These failures could place residents at risk for foodborne illness.Observations of the walk-in refrigerator and interview from 03/03/2026, 9:18 AM - 9:40 AM revealed the following: *9:18 AM, the walk-in fridge contained an opened bottle of Italian dressing dated 2/25/2026. The DM stated it was a received date and it did not have an open date on it because they went by the expiration date. The DM then looked at the bottle and stated it did not have an expiration date written on it. * 9:25 AM, the walk-in fridge contained a steam pan filled with a white, creamy, unidentifiable substance dated 3/02/2026. The DM said that it was cream of mushroom soup and that it did not need to be labeled.*9:26 AM, the walk-in fridge contained an opened container of mayonnaise dated 2/26/2026. The container was not labeled with an open date and the DM stated he was unaware of when it was opened.* 9:28 AM, the walk-in fridge contained five different bags and pans of individually stored meat and egg products sitting on one large steam pan. Only one bag was labeled and this label reflected breakfast and was dated 3/03/2026. The [NAME] stated he labeled one item for the entire tray of items. The DM said that each individual item did not need to be labeled if it was on one tray.* 9:31 AM, the walk-in fridge contained a container of strawberry glaze dated 1/12/2026 had round black spots on the lid. The DM said he did not know if it was mildew because he was not an expert.*9:37 AM, the walk-in fridge contained an opened container of mustard dated 2/21/2026. The container was not labeled with an open date and the DM said, it doesn't really expire.An observation of the dry room storage on 3/03/2026 at 9:45 AM revealed a bag of pecans dated 11/21/2025 was open to air. The pecans were in a resealable bag that was not sealed.An observation of the kitchen on 3/03/2026 at 10:33 AM revealed the fryer was uncovered and was not in use. There were crumbs on top of it and it appeared to be stained with a brown substance. During an observation and interview on 3/03/2026 at 10:34 AM, a small metal pan was sitting above the range top. The pan was covered with a black substance that was flaking off. The [NAME] said, it's just old. An observation of the kitchen on 3/03/2026 at 11:47 AM revealed the back of the stove/oven had several white unidentifiable streaks. The streaks were raised and dry and did not appear wet.An observation of the kitchen on 3/03/2026 at 12:01 PM revealed a trash can next to the three-compartment sink was overflowing and uncovered-the trash can was not in use and all staff were near the service line serving lunch.During an observation and interview on 3/04/2026 at 3:06 PM, the walk-in fridge contained a clear bottle filled with an unidentifiable orange substance. The bottle was not labeled or dated. The DM stated it was thousand island dressing. During an observation and interview on 3/05/2026 at 10:10 AM, the MD observed a picture of the lid for the strawberry glaze dated 3/03/2026 at 9:31 AM. The MD said it looked like mildew from the condensation and humidity in the walk-in refrigerator. The MD said it was cleanable and preventable. The MD said if an item were sitting underneath the fan in the walk-in fridge, it would drip down. The MD said that keeping the door closed more often would prevent it as well because heat from the kitchen created condensation.During an interview on 3/05/2026 at 1:35 PM, the DM said that if items were opened with no best-by date, they would write an opened date and if items were moved out of their original package, they put a best-by date. The DM said he ensured equipment was clean and sanitary by cleaning it. The DM said the small metal pan with the black substance was just wear and tear The DM said he could get a new one, but there was no harm to the food. The DM said the fryer was used for dinner on Monday night (3/02/2026) and Tuesday night (3/03/2026). The DM (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated they were on week 3 of the cycle menu. The DM said he had a cleaning schedule and that the back of the stove/oven was cleaned monthly. The DM said food needed to be sealed, labeled, and dated. The DM said he monitored the kitchen through daily rounds and trained staff upon hire and via in-services. When asked how residents could be affected if food was not stored properly or if sanitation procedures were not followed, the DM said, foodborne illness.During an interview on 3/05/2026 at 4:18 PM, the ADM said the policy on food storage included storing it in a dry, safe area and that it should be dated and labeled. The ADM said the DM had a cleaning schedule and that he monitored the DM to ensure the cleaning schedule was adhered to. The ADM said he reviewed the DM's cleaning schedule with him daily. The ADM said items should be dated when they were opened. When asked if the fryer should be covered when not in use, the ADM said, let me get back to you. The ADM said dietary staff were trained upon hire and annually. When asked how residents could be affected if food were not stored properly or if sanitation policies were not followed, the ADM said hypothetically, they could get sick through cross-contamination.A record review of the cycle menu for week 3 on Tuesday (3/03/2026) reflected that no fried items were on the menu for lunch that day.A record review of the facility's document titled MONTHLY CLEANING SCHEDULE dated 2026 reflected that staff were to clean the inside and outside of the ovens monthly. A record review of the facility's titled Food Storage and Supplies dated 2012 reflected the following: All facility storage areas will be maintained in an orderly manner that preserves the condition of foodand supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, andinsects.Procedure:4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened.9. Perishable items that are refrigerated are dated once opened and used within 7 days (if they do not have an expiration date or best by/use by date), but non-perishable items that are refrigerated once opened should be dated when opened but do not need to be discarded until their expiration date or until the quality has deteriorated. A record review of the 2022 FDA Food Code reflected the following: 3-302.12 Food Storage Containers, Identified with Common Name of Food.Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnable shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. FDA Food Code 2022 Chapter 4 Equipment, Utensils, and Linens Chapter 4 - 21 (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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	03/05/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure that each resident has the right to secure and confidential personal and clinical records for 1 (Resident #92) out of 20 residents reviewed for confidentiality.LVN D left the 400-hall charting computer's screen unlocked with personal medical information of Resident #92 displayed. This failure could result in residents' personal medical information being exposed to unauthorized individuals. Observation on 03/03/2026 at 9:22 a.m. revealed that the charting computer's screen on 400 Hall nursing station was open with Resident #92's personal information displayed and visible to unauthorized individuals, including visitors or other residents not present at that time. The nurse for 400 Hall, LVN D, was not present at the nursing station. She came 5 minutes later to turn the computer screen off.During an interview on 3/03/2026 at 9:26 a.m. with LVN D, she stated that she had an in-service on HIPAA a few months ago and it included instructions on not discussing residents' private clinical information with unauthorized individuals and to lock the computer screen when stepping away from the nursing station. She stated that everybody who worked with charting computers were responsible for closing it and locking it when not in attendance. She stated that leaving the screen unlocked with Resident #92's clinical information left on display could be harmful for this resident as anybody could see it. She stated that she stepped away from the charting computer to answer the call light and forgot to lock the computer's screen.During an interview on 3/05/2026 at 3:41 p.m. with DON, she stated that the facility's policy was to minimize the charting computers' screens when stepping away. She stated that if the screen was not minimized, someone could have unauthorized access to private clinical information displayed on the screen. She stated that HIPAA in-service was provided to all employees at hire and annually through computer modules which include instructions on locking the computer screens. She stated that the person who works with residents' private clinical information should lock the screen before walking away. She stated that the potential negative effect was unauthorized disclosure of residents' private information and could be a dignity issue. During an interview on 3/05/2026 at 4:05 p.m. with ADM, he stated that he had the HIPAA training at hire which covered the importance of maintaining the residents' private information. He stated that whoever used the computer was responsible for shutting it down to ensure the residents' information was not visible. He stated that the potential risk for not shutting down charting computers was a breach of residents' privacy and could affect their dignity. He stated that all staff complete HIPAA in-service at hire and annually through computer modules. He stated that LVN D completed her annual training but he could not provide documentation. Record review of facility's Confidentiality policy, dated 2023, revealed, To guarantee the residents' privacy regarding personal information: 1. No information regarding any resident will be released to any person, organization, or institution without the residents' consent. Record review of facility's Resident Rights policy, undated, revealed The resident has a right to personal privacy and confidentiality of his or her personal and medical records. No policy regarding closing computer screens were available.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish a system of accurate reconciliation and determine that drug records were in order, and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 5 medication carts (400-hall med cart) in the facility affecting 1 resident (Resident # 50) reviewed for pharmacy services.The facility failed to ensure CMA C accurately reconciled Resident #50's narcotic medication log when she administered but did not sign for Resident #50's Lorazepam 0.5mg three tablets. These failures could place residents at risk for loss of prescribed medications, potential for not receiving their prescribed medications, and risk of drug diversion. During an observation on 3/05/2026 at 9:34 a.m of the 400-hall medication cart's reconciliation with the CMA C, revealed the CMA C opened the 400-hall's med cart at the surveyor's request. She was briefed on the purpose of the med cart and controlled medications reconciliation for accuracy with the CMA C showing understanding. The reconciliation of controlled medications on the 400 Hall med cart revealed the blister pack with Lorazepam 0.5mg.Record review of controlled medication log for Resident #50 reflected Lorazepam 0.5mg, three tablets for Resident #50 contained 117 tablets with count of 120 tablets on the.Record review of Resident #50's face sheet, dated 3/05/2026, revealed a 77-years-old female admitted on [DATE]. Resident #50's diagnoses included cerebral infarction (a medical emergency caused by blocked blood flow to the brain, leading to oxygen deprivation and tissue death), anemia (a common blood disorder defined by a deficiency of healthy red blood cells or hemoglobin, leading to reduced oxygen transport to body tissues), and Alzheimer's disease with late onset (the most common form of the dementia, typically developing after age [AGE] and characterized by progressive memory loss, cognitive decline, and personality changes).Record review of Resident #50's quarterly MDS assessment, dated 1/27/2026, revealed BIMS score of 11 indicating the moderate cognitive impairment. Further MDS assessment review for Resident #50 indicated present of mood like feeling down, depressed, or hopeless, but no behaviors like hallucinations or delusions present currently.Record review of Resident #50's care plan, dated 11/19/2025, revealed Resident #50 had behavior problem related to yelling, screaming, hitting with interventions: Administer anti-anxiety medications as ordered by physician. Monitor/document for side effects and effectiveness. Record review of Resident #50's orders, revealed that Resident #50 had an active order, started on 03/05/2026, for Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 3 tablets by mouth three times a day related to generalized anxiety disorder. Record review on 03/05/2026 of MAR for Resident #50 revealed that Lorazepam oral tablet 1.5 mg was administered on 03/05/2026 at 7:00 a.m. by CMA C.During an interview on 3/05/2026 at 9:35 a.m. with CMA C, she said that she administered Resident #50's Lorazepam 0.5mg 3 pills to her this morning but did not sign for it in the controlled medication log reviewed during observation. She said that she was supposed to sign it right away and made a mistake not signing it. CMA C said she got busy and forgot to sign for controlled medications administered to Resident #50 this morning, on 03/05/2026 between 7:00 a.m. and 8:00 a.m. She said that not documenting administration of controlled medications could cause a discrepancy in the count or a medication error, since other nursing staff could not know Resident #50 had already received the controlled medication. She stated that she received the controlled medication administration training annually but could not recall the exact date.During an interview on 03/05/2026 at 3:41 p.m. with DON, she said that she had the medication administration in-service annually and provided this training to nursing staff in the facility annually and on as needed basis. The DON said that charge nurses and CMAs were responsible for monitoring accurate controlled medication count and signing controlled medications as soon as they administered to each resident. She said that herself and the ADONs were auditing the medication carts on a weekly basis. She stated if the administration of controlled medications were not properly (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	counted and signed for, it could lead to a drug diversion and medication error.During an interview on 03/05/2026 at 4:05 p.m. with the ADM, he said that he was not trained on medication administration and storage policy as he was not medically licensed. He said that DON, ADON, charge nurses, and medication aides were responsible for counting controlled medications at shift change and monitoring medications' discrepancies especially with controlled medication to prevent drug diversion and medication errors. He said if a discrepancy was noted, the nurse or med aide was responsible for notifying the ADON, DON or himself. The ADM said that if the controlled medications were not monitored and properly counted it could potentially harm the residents.Record review of facility's PCU019 - Controlled Medications - Administration policy, dated 3/2025, indicated that When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration, amount administered, signature of the nurse administered the dose, completed after the medication is actually administered.Record review of facility's In-Services for last 12 months, 02/2025-02/2026, reveal the record of completed nursing staff training, dated 07/01/2025, on Narcotic in-service: You must sign out narcotics when you pull them, not when you administered them. This in-service was completed and signed by 34 nursing staff including CMA C.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs for 2 of 8 (Resident #72 and Resident #11) residents reviewed for texture-modified diets.The facility failed to serve ground ribs to Resident #72 and Resident #11 who required ground meat.This failure could place residents at risk for choking, reduced intake, and weight loss. 1.A record review of Resident #72's face sheet dated 3/05/2026 reflected a [AGE] year old male admitted on [DATE] with diagnoses of cognitive communication deficit (difficulty communicating), weakness, dysphagia (difficulty swallowing), and need for assistance with personal care. A record review of Resident #72's MDS assessment dated [DATE] reflected that he had a BIMS score of 14, which indicated he had minimally impaired cognition.A record review of Resident #72's care plan last reviewed on 1/12/2026 reflected that he had a mechanically altered diet and staff were to serve his diet as ordered.A record review of Resident #72's diet order dated 10/06/2025 reflected an order for mechanical soft texture.A record review of Resident #72's weight report from 12/08/2025-3/04/2026 reflected no weight loss.2.A record review of Resident #11's face sheet dated 3/05/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of dysphagia (difficulty swallowing), muscle weakness, need for assistance with personal care, and gastro-esophageal reflux disease (acid reflux).A record review of Resident #11's MDS assessment dated [DATE] reflected that she had a BIMS score of 15, which indicated no cognitive impairment. A record review of Resident #11's care plan last reviewed on 3/04/2026 reflected that she required a mechanically altered diet and staff were to offer her a diet as ordered by the physician. A record review of Resident #11's diet order dated 7/07/2025 reflected that she required mechanically ground meat.A record review of Resident #11's weight report from 12/08/2025-2/8/2026 reflected no weight loss.During an observation of lunch service on 3/03/2026 at 12:06 PM, the DM placed some ribs in a blender and pulsed them. When the DM finished pulsing the ribs in the blender, he placed them in a steam pan and put them on the service line. The pulsed ribs appeared stringy and were not ground. During an observation and interview on 3/03/2026 at 12:17 PM, Resident #11 was observed eating in the dining room. When asked how her meal was, Resident #11 stated, it would be better if I could eat the meat. Resident #11 stated that the meat just wouldn't go down. Resident #11 stated that her meat needed to be mechanically chopped and it looked like they just pulled it apart. Resident #11 said, I need it to be juicy so it goes down. Observed that Resident #11's meal ticket listed GROUND MEAT in two different places. During an interview on 3/04/2026 at 12:21 PM, Resident #11's family member said that Resident #11 complained to him about the meat. Resident #11's family member said he knew that Resident #11 had talked to the aides and to the SW but they might be understaffed. Resident #11's family member said that Resident #11 complained about the meat being hard to swallow and said she saw a speech therapist.During an observation and interview on 3/03/2026 at 12:27 PM, Resident #72 was observed eating at a table. Resident #72's meal ticket reflected that his meat needed to be grounded but it was observed to be shredded. Resident #72 said he was able to eat it okay.During an observation and interview on 3/03/2026 at 12:30 PM, LVN I stated she was responsible for checking meal trays that day during lunch. LVN I stated she checked for texture when checking trays. LVN I looked at Resident #11's tray and said her meat did not look ground up like hamburger meat. LVN I looked at Resident #72's plate and said no it did not look ground. LVN I said Resident #72 should have mechanical soft meat. LVN I said she did not see anyone get ground meat and that she would have to ask the DM about that.During an observation and interview on 3/05/2026 at 10:58 AM, the DOR stated that she was a speech therapist. The DOR stated that Resident #72 had a history of stroke, had dysphagia (difficulty swallowing), and required ground meat. The DOR said that Resident #11 used to receive speech therapy services for weight loss and she required mechanical (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soft meat. The DOR said mechanical soft meat should be like hamburger meat. The DOR said Resident #11 was kyphotic (curved spine) and that absolutely contributed to Resident #11's swallowing difficulty. The DOR stated that Resident #72 had a history of stroke and required ground meat. The DOR observed a photo taken by the HHSC surveyor dated 3/03/2026 at 12:24 PM of Resident #11's tray and said the meat did not look ground. The DOR said residents could have aspiration if they were served meat that was not ground. The DOR stated that neither Resident #11 nor Resident #72 had any choking incidents that she could recall.During an interview on 3/05/2026 at 1:45 PM, the DM said he could not tell the surveyor the policy on texture-modified diets verbatim, but that mechanical soft was a ground beef texture for meats. The DM said staff were trained through hands-on training and that he already had the knowledge upon hire. The DM said he monitored to ensure food was the appropriate consistency by watching staff prepare it. The DM said he was unaware that Resident #11 and Resident #72 received meat that was not ground. The DM said that charge nurses checked trays and cooks checked as they were plating the food. The DM said if food was not the correct texture, it could be a choking hazard.An attempt to interview the RD was made on 3/05/2026 at 3:02 PM, a detailed voicemail was left requesting a call back but the call was not returnedDuring an interview on 3/05/2026 at 3:47 PM, the DON stated that trays were passed through multiple hands-the DM, CNAs nurses, and cooks-and that they were all educated. The DON said nurses and CNAs checked trays to see if the ticket matched the tray. When asked why Resident #11 and Resident #72 received chopped meat instead of ground met, the DON said it was a possible oversight. The DON said if residents received food that had the incorrect texture, they could choke. During an interview on 3/05/2026 at 4:22 PM, the ADM said the kitchen staff used a machine to mince and chop meat and that cooks were trained upon hire, annually, and as needed. The ADM said trays went through several check points starting with the cook .The ADM said their policy was that a department head was in the dining room with a licensed nurse to check that food matched the ticket. The ADM stated that once it was cleared by the nurse, they gave it to a CNA to be passed to residents. The ADM said if food was not truly ground, residents could aspirate. A record review of the facility's policy titled MECHANICAL SOFT DIET OR REGULAR WITH MECHANICAL GROUND MEAT DIET dated 2025 reflected the following: The Mechanical Soft Diet is designed to provide a texture modification of the Regular Diet orany other therapeutic diet for persons with chewing or swallowing difficulty. Minced and moistmeat and flaked fish is served in sauce or gravy, with an average particle size of approximately 4mm (slightly less than half a centimeter) in width and less than 15 mm (1 1/2 centimeters) inlength; most fruits and vegetables are not served raw, and others may be finely or coarselychopped. Fried breaded vegetables are not served. The Mechanical Soft Diet is individualized asneeded. If a resident can tolerate regular consistency fruits and vegetables, a Regular with MechanicalGround Meat Diet may be appropriate. This diet will consist of the Regular Diet, but mincedand moist meat and flaked fish is served in sauce or gravy, with an average particle size ofapproximately 4 mm (slightly less than half a centimeter) in width and less than 15 mm (1 /2centimeters) in length. No other consistency modifications will be made. If a resident requestswhole meats, a doctor's order must be obtained.