

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675982	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  Park Plaza Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 Howard St San Angelo, TX 76901	

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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593</b></p> <p>Based on observation, interview, and record review the facility failed to ensure 1 of 7 residents (Resident #36) with indwelling urinary catheters received appropriate care to prevent urinary tract infections to the extent possible.</p> <p>Resident #36's indwelling catheter tubing was dragging on the floor on 3 of 3 days observed.</p> <p>This failure could place residents with indwelling urinary catheters at risk of infection.</p> <p>The findings included:</p> <p>Resident #36</p> <p>Record review of Resident #36's admission record dated 03/13/25 indicated he was admitted to the facility on [DATE] with diagnoses of muscle weakness, reduced mobility and retention of urine. He was [AGE] years of age.</p> <p>Record review of Resident #36's care plan dated 10/17/2024 indicated in part: Focus: The resident has an indwelling catheter. Goal: The resident will be/remain free from catheter-related trauma through review date. Interventions: Check tubing for kinks and maintain the drainage bag off the floor.</p> <p>Record review of Resident #36's annual MDS assessment dated [DATE] indicated in part: BIMS = 15 indicating resident was cognitively intact. Appliances had indwelling catheter, Urinary continence = Not rated, resident had a catheter.</p> <p>Observation on 3/11/25 at 12:10 pm Resident #36 self-propelling in wheelchair with foley catheter tubing dragging on the floor.</p> <p>Observation on 3/12/25 at 12:32 pm Resident #36 self-propelling in wheelchair with foley catheter tubing dragging on the floor.</p> <p>Observation on 3/13/25 at 3:20 pm Resident #36 self-propelling in wheelchair with foley catheter tubing dragging on the floor.</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/13/25 at 03:10 PM the DON said the bag and/or tubing should not be touching the floor as that could lead to a possible infection and cross contamination. The DON said due to the tubing touching the floor could lead to the risk of infections and possible cross contamination. The DON said the failure occurred probably because the catheter tubing was too low when Resident #36 was placed on his wheelchair. She stated this is a new wheelchair that is smaller than normal, and this may be the reason it is dragging. The DON was not aware that the tubing was dragging.</p> <p>Record review of facility policy titled Catheter Care dated 2/13/2007 revealed a subsection under general guidelines 10. Be sure the catheter tubing and drainage bag are kept off the floor.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30057</p> <p>Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice for 1 of 4 (Resident #3) reviewed for respiratory care.</p> <p>Resident #3's oxygen nasal cannula and SVN mask were not covered in a plastic bag when they were not used.</p> <p>These failures could place all residents who use respiratory equipment at risk for respiratory infections.</p> <p>The findings included:</p> <p>Record review of Resident #3's admission record dated 03/13/25 indicated she was admitted to the facility on [DATE] with diagnoses of muscle weakness and hypoxemia (Low blood oxygen). She was [AGE] years of age.</p> <p>Record review of Resident #3's care plan dated 10/17/2024 indicated in part: (Focus: Resident has impaired oxygen exchange and shortness of breath r/t COPD and hypoxemia. Uses oxygen @ 3 liters per minute continuously when asleep &amp; PRN during the daytime. Goal: Resident will have adequate air exchange as evidenced by normal breathing patterns and usual mental status through the review period. Interventions: Assure that Resident has oxygen on and there is no kink in tubing.</p> <p>Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated in part: BIMS = 10 indicating resident was moderately impaired. Respiratory Treatments - Oxygen therapy.</p> <p>Record review of Resident #3's Physicians Orders dated 03/13/2025 documented in part: Change O2 tubing and nasal cannula as needed when visibly soiled or malfunctions.</p> <p>During an observation and interview on 03/11/25 at 10:35 AM Resident #3's nasal cannula tubing was seen wrapped around the oxygen tank on her wheelchair. During further observation the resident's SVN mask was seen resting on top of the dresser on and not bagged. The resident was seen in her bed awake and alert and wearing an oxygen cannula that was connected to an oxygen machine. Resident #3 said that when she used her wheelchair she would use the oxygen cannula to get around that was connected to the oxygen tank. The resident said staff had wrapped the nasal cannula tubing around her oxygen tank to store it while she was not using it. Resident #3 said she used the SVN mask to get breathing treatments and was not sure why the SVN mask and nasal cannula were nor placed in a plastic bag.</p> <p>During an interview on 03/13/25 at 11:10 AM RN D said that whenever a resident was not using their oxygen that it was supposed to be stored in a bag so that the nasal cannula was not in danger of becoming contaminated. RN D said it was the same expectation for the SVN masks, that if they were not being used the mask were supposed to be kept in a bag to prevent contamination which could lead to respiratory infections.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/13/25 at 03:08 PM the DON said it was expected for the oxygen cannula tubing and SVN mask to be stored in a bag when not in use. The DON said if the items were not stored in a bag and left out it could lead to potential cross contaminations and infections. The DON said the failure probably occurred because the staff forgot to change the oxygen tubing and SVN masks and store them in a bag.</p> <p>During an interview on 03/13/2025 at 3:46 PM the ADO was made aware of the oxygen items left out and not stored in bags. The ADO said oxygen items left out like that could lead to cross contamination.</p> <p>Record review of the facility's policy titled Respiratory policies and procedures dated June 1, 2006 indicated in part: Oxygen therapy via nasal cannula is administered as ordered by a physician and includes correct flow rate, mode of delivery and frequency. Gather supplies - Treatment bag-replace entire set-up every seven days, date and store in treatment bag when not in use. Aerosol mask - oxygen therapy via aerosol mask is administered as ordered by a physician and includes flow rate, concentration, mode of delivery and frequency. Gather supplies, replace entire set-up every seven days. Date and store in treatment bag when not in use.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>30057</p> <p>Based on observation, interview and record review the facility failed to store all drugs and biologicals in locked compartments for 1 of 2 nurse medication carts (The north hall medication cart) reviewed for medication storage and security.</p> <p>LVN C failed to ensure the nurse medication cart for the north hall was secured when it was left unattended.</p> <p>These failures could place residents at risk for drug diversion or accidental ingestion.</p> <p>Findings included:</p> <p>During an observation on 03/11/25 at 10:20 AM the nurse medication cart on the north hall was observed unlocked and unattended.</p> <p>During an observation and interview on 03/11/25 10:25 AM LVN C was observed coming out of a resident's room. LVN C said that it was her nurse medication cart and it was her that had accidentally left it open. LVN C said she had stepped away to help one of the staff members and had forgotten to lock the cart. LVN C said leaving the cart unlocked and unattended could lead to unauthorized people having access of the cart. Inside the cart were several bubbled packed prescribed medications, insulin pens and other over the counter medications.</p> <p>During an interview on 03/13/25 at 03:04 PM the DON said it was expected for the medication carts to be locked when left unattended. The DON said if the cart was left unlocked and unattended that could lead to a risk of residents or visitors having access to the cart. The DON said the failure probably occurred because the nurse was called out to assist a staff member and she forgot to lock the cart.</p> <p>During an interview on 03/13/2025 at 3:44 PM the ADO was made aware of the medication cart left unlocked. The ADO said if the cart was left unlocked and unattended that could lead to unauthorized people getting into the cart.</p> <p>Record review of the facility's policy Medication Administration Procedures dated 2003 indicated in part: All medications are administered by licensed medical or nursing personnel. During the medication administration process the unlocked side of the cart must always be in full view of the nurse. After the medication administration process is completed, the medication cart must be completely locked or otherwise secured.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30057</p> <p>Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #36) of 7 residents reviewed for infection prevention and control.</p> <p>CNA A and CMA B failed to change her gloves when going from dirty to clean during Resident #36's incontinent care.</p> <p>CNA A and CMA B failed to use PPE during incontinent care and urinary catheter care performed for Resident #36 as the resident was on EBP precautions.</p> <p>These failures could place residents at risk of infections, secondary infections, and communicable diseases.</p> <p>Finding include:</p> <p>Record review of Resident #36's admission record dated 03/13/25 indicated he was admitted to the facility on [DATE] with diagnoses of muscle weakness, reduced mobility, and retention of urine. He was [AGE] years of age.</p> <p>Record review of Resident #36's care plan dated 10/17/2024 indicated in part: (Focus: Resident is on enhanced barrier precautions. Goal: There will not be any transmission of infection from or to the resident. Interventions: Gloves and gown should be donned if any of the following activities are to occur- resident hygiene, transfer, dressing, toileting/incontinent care).</p> <p>Record review of Resident #36's annual MDS assessment dated [DATE] indicated in part: BIMS = 15 indicating resident was cognitively intact. Bladder and Bowel = Urinary Continence Not rated, resident had a catheter. Bowel Continence - Always incontinent.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 03/11/25 at 11:04 AM CNA A and CMA B performed incontinent care on Resident #36. CNA A brought in a sit to stand lift machine and connected it to the sling the resident already had wrapped around and under his shoulders. Both staff members sanitized their hands and put gloves on. CNA A then pressed the button on the machine and raised the resident to a standing position. CNA A then undid the resident's brief, and it was noted that he had - had a bowel movement. Both CNA A and CMA B took some wet wipes and wiped the bowel movement. It was noted that the resident had a urinary catheter which was attached to his penis and secured to his leg. After CMA B wiped the bowel movement from the resident's rectal area she took some wet wipes and wiped the resident's catheter and penis area while still wearing the same gloves she used to wipe the resident's bowel movement. While still wearing the same gloves she used to wipe Resident #36's bowel movement, CNA A took the old brief and placed it in the trash and then took the new brief and fastened it to the resident. CNA A then pulled Resident #36's pants up and then took the lift machine remote and pressed the down button to lower the resident back unto his wheelchair while still wearing the same gloves that she had used to wipe the resident's bowel movement. Neither of the CNA's were noted to wear any PPE be sides the gloves as outside the resident's door was a posting that indicated Multidrug-resistant organisms (MDROs) are a threat to our residents, Enhanced Barrier Precautions (EBP) steps.</p> <p>During an interview on 03/11/25 at 11:28 AM CNA A said she should have changed her gloves before she applied the new brief, pulled the resident's pants and pressed the remote buttons on the lift to stand machine. CNA A said if she did not change her gloves then it could lead to the spread of infections and cause cross contamination. CNA A said she had forgotten to change her gloves at the proper time. When asked about the posting regarding MDROs posted outside Resident #36's door and if it applied to them during incontinent care CNA A said she was not sure why the posting was there and did not believe it applied to them for incontinent care.</p> <p>During an interview on 03/11/25 at 02:36 PM CMA B said she should have changed her gloves before she performed catheter care to the resident's penis area as she had just wiped the resident's bowel movement with the same gloves. CMA B said not changing her gloves could lead to UTI's and cross contamination. When asked about the posting regarding MDROs posted outside Resident #36's door and if it applied to them during incontinent care CMA B said she was not sure why the posting was there and did not believe it applied to them for incontinent care.</p> <p>During an interview on 03/13/2025 at 3:08 PM the DON said whenever a resident was on EBP staff were expected to use PPE such as gloves and gowns. The DON said staff were expected to wear EBP for Resident #36 during the incontinent care as he had a urinary catheter. The DON said staff not wearing EBP could possibly lead to the spread of infection to others due to possible cross contamination. The DON said the failure probably occurred because the staff was in a hurry, and that the staff would be re-educated on the use of EBP and when to use it. The DON said CMA B should have changed her gloves before she performed incontinent care to Resident #36's urinary catheter. The DON said CNA A should have changed her gloves after she had wiped the resident's bowel movements and then proceeded to do other tasks such as touching the new brief. The DON said the ADON and herself would monitor for infection control by doing rounds and in-services. The DON said she believed the failure occurred because the staff got nervous and forgot the steps.</p> <p>During an interview on 03/13/2025 at 3:48 PM the ADO was made aware of the staff not changing their gloves or using EBP during incontinent care performed on Resident #36. The ADO acknowledged that staff not changing their gloves or using EBP could lead to cross contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled Infection control plan overview and dated 03/2024 indicated in part: Infection control - the facility will establish and maintain an infection control program designed to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Infection control program the facility will establish an infection control program under which it investigates, controls, and prevents investigations in the facility. Maintains a record of incidents and corrective actions related to infections.</p> <p>Record review of the facility's policy titled Catheter care and dated 02/23/2007 indicated in part: Provide perineal care to the incontinent resident to prevent skin rashes and breakdown. Procedure - gather supplies, gloves, pre-moistened no-rinse disposable wash cloths, wash your hands thoroughly with soap and water or alcohol, apply gloves, gently was rinse and dry around the juncture of the catheter and meatus. If using pre-moistened no-rinse disposable wash cloths, rinsing is not required, then wash the catheter from the meatus down the tube about 3 inches, dispose of wash cloths, remove gloves and wash hands.</p> <p>Record review of the facility's undated policy titled Enhanced barrier precautions indicated in part: Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug- resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more that 1 patient. EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices examples include central lines, urinary catheters.</p> <p>Record review of the facility's policy titled Perineal Care Male and dated 12/08/2009 indicated in part: Purpose to clean the male perineum without contaminating the urethral area with germs from the rectal area. Beginning steps, wash hands, gather needed supplies, expose the resident's perineal area, if heavy soiling is present, wear gloves and use tissues or wipes to remove heavy soiling prior to perineal care. Wash hands and put on clean gloves for perineal care, gently wash perineal area wiping from clean urethral area toward dirty rectal area to avoid contaminating urethral area with germs from the rectum. If at any time your gloves become contaminated with feces change gloves.</p>		