STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675982	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Plaza Nursing and Rehabilitation Center	2210 N 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)
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 residents had the right to personal privacy and confidentiality of his or her personal and medical records for 2 of 5 residents (Resident #2 and Resident #43) reviewed for privacy, in that:The facility failed to ensure LVN A locked the computer, which exposed Resident #2's morning medication list after she walked away and left the computer unattended.The facility failed to ensure LVN B locked the computer, which exposed Resident #43's lunch time medication list after she walked away and left the computer unattended.This failure could place residents at risk of having medical information exposed to others and cause residents to feel uncomfortable and disrespected.The findings include:Record review of Resident #2's face sheet dated 5.12.26 reflected an 85 - year old female who was admitted to the facility on 11.7.25 with diagnoses which included: Chronic Obstructive Pulmonary Disease (lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), Respiratory Failure, and Congestive heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently, causing blood to back up and fluid to accumulate in the lungs, legs, and other organs.). Record review of Resident #2's Quarterly MDS assessment, dated 3.4.26, reflected a BIMS score of 12 which indicated moderate cognition impairment.Record review of Resident #43's face sheet dated 5.12.26 reflected an 80- year old male admitted to the facility on 3.22.25 with diagnoses included: Chronic Obstructive Pulmonary Disease (lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), Dysphagia (the medical term for difficulty swallowing, indicating a disruption in the process of moving food or liquid from the mouth to the stomach. Symptoms include coughing, choking, or a sensation of food sticking in the throat or chest), and Type 2 Diabetes.Record review of Resident #43's Quarterly MDS assessment, dated 4.15.26.26, reflected a BIMS score of 15 which indicated no cognition impairment.An observation on 5.12.26 at 11:15 am revealed LVN A prepared Resident #2's medication on the medication cart and walked away from the computer revealing Resident #2's medication list, LVN A did not lock the computer screen.An observation on 5.13.26 at 11:40 am revealed LVN B left the nurses station to answer a call light and walked away from the computer revealing Resident #43's medication lists, LVN B did not lock the computer screen.During an interview on 5.12.26 at 2:15 pm, LVN A stated that she did not realize she had left her computer open with resident information on it. She stated she normally was good about closing her computer. She stated she should have shut it because the resident's information could be seen by anyone that walks by which is against the resident's privacy. During an interview on 5.13.26 at 1:15 pm LVN B stated that due to the location of the computer she thought the computer was blocked enough for nothing to be observed. She stated that coming from down the hallway and looked at the screen, she could observe Resident #43's information. She stated she did not realize the computer screen could be seen and would make sure to not leave any resident information up on that computer anymore.During an interview on 5.14.26 at 2:00 pm, the DON stated that she was notified that computer screens had been left open with resident information. She stated that should not have happen. She stated her expectations was that anytime any of her staff leave a computer it should either be shut or the screen minimized to not expose resident information. She stated the negative outcome was that the resident's personal information (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be seen, such as SSN, DOB, medications etc.Record review of the facility's policy titled, Resident Rights, not dated, reflected: Privacy and Confidentiality-the resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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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 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 observations, interviews, and record review it was determined the facility failed to provide pharmaceutical services that ensure the accurate administering of drugs for 1 of 2 nurse medication carts (South Hall) observed for medications stored. properly labeled and accounted for. The South Hall nurse medication cart had two controlled medication blister packs that did not match their corresponding controlled medication count sheet. This failure could place residents at risk of underdose, overdose or drug diversion. Findings included: Review of Resident #4's admission record dated 05/14/2026 revealed the resident was admitted to the facility on [DATE] with diagnosis of pain. He was [AGE] years of age. Review of the current care plan for Resident #4, last reviewed/revised: 03/25/2026, revealed in part: The resident is on Pain medication. The resident will be free of any discomfort or adverse side effects from pain medication through the review date. Administer medication as ordered. Review of Resident #4's physician orders dated 05/14/2026. Hydrocodone-Acetaminophen (narcotic pain medication) oral tablet 10-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain. Review of Resident 51's admission record dated 05/14/2026 revealed the resident was admitted to the facility on [DATE] with diagnosis of chronic pain. He was [AGE] years of age. Review of the current care plan for Resident #51, last reviewed/revised: 05/12/2026, revealed in part: The resident is on pain medication therapy related to disease process hip fracture/infection right hip joint, hardware removal and chronic pain. Review of Resident #51's physician orders dated 05/14/2026. Hydrocodone-Acetaminophen oral tablet 10-325 MG. Give 2 tablet by mouth every 4 hours as needed for Pain Right Hip. Observation and record review on 05/12/2026 at 9:10 AM, the north hall medication cart was inspected with LVN A present. The controlled medications were inspected, and the count was compared with the matching count sheet. There were 2 medication blister packs that the count was incorrect when compared to the corresponding count sheets. The medications were as follows: 1 blister pack of hydrocodone/APAP tablet 10/325mg that belonged to Resident #51 that contained 30 tablets. Resident #51's corresponding count sheet indicated the count was 28 and that 2 tablets were administered on 05/12/26 at 8:20am. There was 1 blister pack of hydrocodone/APAP tablet 10/325mg that belonged to Resident #4 that contained 47 tablets. Resident #51's corresponding count sheet indicated the count was 46 and that 1 tablet was administered on 05/12/26 at 7:45am. (APAP - Acetaminophen pain medication). Interview on 05/12/2026 at 9:12 AM, LVN A said she had signed the medications out on the control count sheets but had not administered it yet as she was planning on it but had gotten busy with other things. The LVN said she should not have signed them out and waited till she administered them or else the count would be incorrect and the residents might have not received their medications. Interview on 05/14/2026 at 1:22 PM Resident #4 said he received his pain medication as needed. He said he had a regular pain medication that he received and had a stronger pain medication that he could request as needed. Interview on 05/14/2026 at 1:26 PM Resident #51 said he had no concerns about receiving his pain medication as needed. He said the staff were good about asking him if he had any pain and would administer his medication as needed. Interview on 05/14/2026 at 2:44 PM, the DON said it was expected for the nurse to give the controlled medication and then to sign it out after it was given. The DON said if the controlled medication was signed out but not given then that could lead to the count being incorrect if the nurse forgot to administer the medication. The DON said a possible outcome could be the resident not getting their medication and not knowing when they received their last dose. Interview on 05/14/2026 at 2:52 PM, the Administrator said he agreed with what the DON said regarding the controlled medication count. He said he had the same expectations as the DON stated and also the possible outcomes. Record review of the facility's policy titled Medication Administration Procedures and dated 10/25/17 indicated in part: All medications are administered by licensed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical or nursing personnel. Medications are to be poured, administered and charted by the same licensed person. After the resident had been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration. All nurses administering medications must sign and initial the designated area of each resident's medication/treatment administration record or resident specific master signature log for identification of all initials used in charting.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication carts (South hall) reviewed for medication storage. The south hall nurse medication cart had one insulin pen that belonged to Resident #5 that had been opened but not dated when it was placed into use. This failure could place residents at risk of receiving medications that were expired and not produce the desired effect. Findings included: Review of Resident #5's admission record dated [DATE] revealed he was admitted to the facility on [DATE] with diagnosis of diabetes. He was [AGE] years of age. Review of the current care plan for Resident #5, last reviewed/revised: [DATE], revealed in part: The resident has Diabetes. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of Resident #5's physician orders dated [DATE]. Insulin Aspart Subcutaneous Solution Cartridge, inject as per sliding scale: Subcutaneously (Under the skin) before meals and at bedtime related to diabetes. Observation and interview on [DATE] at 9:14 AM, the south hall medication cart was inspected with LVN B present. Inside the top drawer of the cart were several insulin pens. There was one insulin pen that belonged to Resident #5 that had been opened but there was no open date found on the pen. LVN B said she did not know who had opened the pen. The DON was passing by and was made aware of the undated insulin pen. The DON said that once an insulin pen was opened it was good for 28 days. Interview on [DATE] at 2:44 PM, the DON said it was expected for the nurse to give the controlled medication and then to sign it out after it was given. The DON said if the controlled medication was signed out but not given then that could lead to the count being incorrect if the nurse forgot to administer the medication. The DON said a possible outcome could be the resident not getting their medication and not knowing when they received their last dose. The DON said it was expected for the nurses to date the insulin pens after they were initially opened. The DON said the insulin pens were good for 28 days after they were opened. The DON said a possible outcome of a resident receiving an expired insulin could be that the medication might not function as indicated. The DON said that it was each nurses responsibility to monitor the medication cart for insulin pens being dated before administering it. Interview on [DATE] at 2:52 PM, the Administrator said he agreed with what the DON said regarding the controlled medication count and the undated insulin pen. He said he had the same expectations as the DON stated and also the possible outcomes. Record review of the facility's policy titled Insulin pen use and dated [DATE] indicated in part: Once you take the insulin pen out of cool storage you can use it for up to 28 days. Ensure that the pen is dated when placed into use. During this time, it can be safely kept at room temperature up to 86 degrees Fahrenheit. Do no use it after this time.