

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/19/2024
NAME OF PROVIDER OR SUPPLIER  Park Place Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2450 E Fifth St Tyler, TX 75701	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46929</p> <p>Based on interviews and record review, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for 1 of 1 residents (Resident #1) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #1's RP was notified after she had a fall and sustained injuries.</p> <p>This failure could put residents at risk for a decreased quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 05/19/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included non-ST elevation myocardial infarction (a type of heart attack that usually happens when your heart's need for oxygen can't be met), history of falling, cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of Resident #1's significant change MDS assessment, dated 05/10/24, indicated she had a BIMS score of 11, which indicated moderate cognitive impairment. She exhibited behaviors of rejection of care 1 to 3 days of the assessment window. She used a walker and a wheelchair as a mobility device.</p> <p>Record review of Resident #1's care plan, printed on 05/19/24, indicated a care area/problem of cognitive deficit: Decision-making, onset 05/06/24. Interventions included monitor for any changes or decline in cognitive status.</p> <p>Record review of Resident #1's incident / accident report, dated 05/17/24, indicated the incident occurred on 05/17/24 at 5:35PM. The report further indicated the family was notified on 05/18/24 at 10:25AM.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/19/24 at 8:22AM, the Administrator called this state surveyor and said Resident #1 had a witnessed fall in the facility. He said the resident fell in the hall. He said the facility did everything they were supposed to except the nurse did not immediately notify the family. He said the family was not notified until the next morning. He said a family member came to visit Resident #1, found the bruise and abrasion to her face, and became upset because she was not notified about the fall. He said the family took the resident out of the facility. He said the family told him that they were going to move her out of the facility to somewhere closer to her family.</p> <p>During an interview on 05/19/24 at 8:55AM, RN A said she was assigned to Resident #1 on the evening of her fall. She said another staff member told her that the resident was on the floor in the hall. She said she immediately assessed Resident #1 and found that she had a small bruise to her left eye and an abrasion to the left side of her face. She said both were around the size of a nickel. She said Resident #1 refused to allow RN A to check her vital signs. She said Resident #1 was adamant she did not want anyone to do anything for her. She said she attempted to check neuros and the resident refused each one. She said Resident #1 was adamant she was going to go home soon. She said Resident #1's cognition varies. The staff often had to redirect her. She said the family came to the facility the next morning after the fall and noticed the bruise and abrasion to Resident #1's face. She said they were upset that they were not notified about the fall or injuries. She said she should have called the family immediately after the resident fell . She said she did not remember until the family had complained that they were not notified. She said Resident #1 usually refused care and told staff that she was going to go home soon.</p> <p>During an interview on 05/19/24 at 9:09AM, LVN B said if a resident fell on her shift, she would immediately call the family.</p> <p>During an interview on 05/19/24 at 9:18AM, ADON C said she was the ADON for the lower level of the facility. She said that Resident #1's cognition varies. She said Resident #1 cannot make her own decisions. She said since she cannot make her own decisions the nurse should have called the family immediately after the fall. She said that when she saw the resident after the incident, she observed a bruise above Resident #1's eye, and an abrasion under her eye, both smaller than a nickel in size. She said if a resident fell and had clear signs of head trauma or major head injury or deficits then they would send the resident to the hospital. She said Resident #1 was known to refuse care, and after the incident she was back to herself and ambulating around the facility.</p> <p>During an interview on 05/19/24 at 9:59AM, the DON said she was off on PTO when the incident occurred. She said she expected the nurse to call the family as soon as possible. She said typically the nurses call the family when they are filling out the incident report. She said if that nurse cannot call the family, then it was the next shift's responsibility. She said when the family was not notified it can cause a misunderstanding.</p> <p>During an interview on 05/19/24 at 10:14AM, Resident #1's RP said the facility did not call her when the fall occurred. She said after she heard about the incident from Resident #1's other family member she called the facility and asked what happened. She said the nurse apologized and said it was right before my shift ended. She said she would not allow Resident #1 to come back to the facility because she felt she would be unsafe.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/19/24 at 10:00AM, the Administrator said he expected the nurse to call the family when a fall occurred. He said it could cause a misunderstanding between the facility and the Resident's family. It could cause the family to be unable to know to tell the facility to send the resident to the hospital.</p> <p>Record review of the Facility's policy, Fall Management, effective 01/12/18, stated:</p> <p>.Procedures .</p> <p>.4. If a fall occurs, the qualified staff assesses for injury from the fall, immediately investigates the reason and determine the intervention to prevent future falls - complete the incident/accident report in the EHR .</p> <p>.5. The physician and family are notified .</p>		