

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 08/05/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>Based on interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering, and receipt of all drugs and biologicals, to meet the needs of 1 of 6 (Resident #1) residents reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #1 received Sodium chloride 2000 mg every 8 hours, as indicated on his hospital after visit summary, from 03/05/24 through 07/24/24. Resident #1 was administered the incorrect dose of Sodium chloride 1000 mg every 8 hours (12:00 a.m., 8:00 a.m., and 4:00 p.m.) from 03/05/24 through 07/18/24 and from 07/20/24 through 07/24/24. Resident #1 was not administered Sodium chloride at 12:00 a.m. on 07/19/24.</p> <p>This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications.</p> <p>Findings included:</p> <p>Record review of Resident #1's facesheet, dated 08/03/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included intracranial injury (brain dysfunction caused by an outside force, usually a violent blow to the head), fracture of neck (a break in one or more of the bones in the neck), hypoxemia (low level of oxygen in the blood), disorientation (a state of mental confusion), and chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). MD B was his attending physician.</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 07/23/24, indicated his BIMS score was 99, which indicated he was unable to finish the BIMS interview. He was usually able to make himself understood and he was sometimes able to understand others. His cognitive skills for daily decision making were severely impaired. His MDS also indicated a diagnosis of hyponatremia (abnormally low concentration of sodium in the blood).</p> <p>Record review of Resident #1's hospital After Visit Summary, dated 03/05/24, indicated this medication order:</p> <p>*Sodium chloride 1,000 mg tablet, soluble. Take 2 tablets (2,000 mg total) by mouth every 8 hours.</p> <p>Record review of Resident #1's physician's order's, printed on 08/03/24, indicated this order:</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Sodium chloride 1,000 mg soluble tablet (sodium chloride) 1 tablet, soluble G-tube every 8 hours. The start date was 03/05/24.</p> <p>Record review of Resident #1's MAR, dated 03/05/24 through 03/31/24, indicated Resident #1 was administered 1 tablet every 8 hours (12:00 a.m., 8:00 a.m., and 4:00 p.m.) from 03/06/24 through 03/31/24.</p> <p>Record review of Resident #1's MAR, dated 04/01/24 through 04/30/24, indicated Resident #1 was administered 1 tablet every 8 hours (12:00 a.m., 8:00 a.m., and 4:00 p.m.) from 04/01/24 through 04/30/24.</p> <p>Record review of Resident #1's MAR, dated 05/01/24 through 05/31/24, indicated Resident #1 was administered 1 tablet every 8 hours (12:00 a.m., 8:00 a.m., and 4:00 p.m.) from 05/01/24 through 05/31/24.</p> <p>Record review of Resident #1's MAR, dated 06/01/24 through 06/30/24, indicated Resident #1 was administered 1 tablet every 8 hours (12:00 a.m., 8:00 a.m., and 4:00 p.m.) from 06/01/24 through 06/30/24.</p> <p>Record review of Resident #1's MAR, dated 07/01/24 through 07/24/24, indicated Resident #1 was administered 1 tablet every 8 hours (12:00 a.m., 8:00 a.m., and 4:00 p.m.) from 07/01/24 through 07/18/24. Resident #1 was not administered the midnight dose on 07/19/24. Resident #1 was administered 1 tablet every 8 hours (12:00 a.m., 8:00 a.m., and 4:00 p.m.) from 8:00 am on 07/19/24 through 08:00AM on 07/24/24.</p> <p>Record review of Resident #1's Nurses notes, dated 07/24/24, indicated Resident #1 was sent to the hospital for wound management on 07/24/24.</p> <p>During an interview on 08/05/24 at 10:05AM, the ADON said the typical procedure for entering the hospital discharge orders was that the admitting nurse would put in the orders from the hospital after visit summary into the EMR and then the ADON was supposed to review them. She said she was likely the person that put in the orders, and it was an oversight.</p> <p>During an interview on 08/05/24 at 10:13AM, LVN A said she was the nurse that admitted Resident #1. She could not remember if she put the hospital orders in the EMR or if the ADON did. She said the typical procedure was that either the ADON or admitting nurse would put in the orders from the hospital. She said it just depended on who was free at the time of the admission.</p> <p>During an interview on 08/05/24 at 10:24AM MD B said he was the attending physician for Resident #1. He said he expected the nurses to enter the orders as they were ordered from the hospital after visit summary. He said he thought it was a transcription error. He said there was not a difference from the oral to the G tube order. He said no one called him to get the order changed. He said he did not change the hospital discharge order.</p> <p>During an interview on 08/05/24 at 10:30AM the ADM said his expectation was for the nurse to reach out to the doctor and ask for clarification if they were unsure about the order, especially if the order was for by mouth and the resident took medications by g-tube.</p> <p>(continued on next page)</p>		

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<p>F 0755</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 Physician Orders - Electronic, last reviewed 11/26/23, stated:</p> <ol style="list-style-type: none"> .1. The licensed nurse will receive and transcribe the physician's orders according to Practice Guidelines. 2. The licenses nursing staff will provide residents with medications and treatments as ordered by his/her physician . <p>Record review of the facility's policy Physician Orders (Admission), last revised 1/12/20, stated:</p> <ol style="list-style-type: none"> .The licensed nurse will obtain and transcribe orders according to Practice Guidelines . .1. The licensed nurse reviews orders from the transfer record from an acute care hospital or other entity. 2. A call is placed to the physician to confirm the orders and request any additional orders as needed .