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| 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 01/29/2025 |
| 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) |
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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140</p> <p>Based on observations, interviews, and record reviews, 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 3 of 3 residents (Residents #1, #2, and #3) reviewed for Enhanced Barrier Precautions.</p> <p>The facility failed to provide containers with clean PPE products and containers to discard used PPE on the halls or nearby the rooms of Residents #1, #2, and #3.</p> <p>CNA A and Corporate Regional RN failed to don PPE when they pulled Resident #1 up in bed.</p> <p>CNA E failed to don PPE while transferring Resident #3 on a mechanical lift, adjusting his urinary catheter drainage bag, or while assisting him to brush his teeth.</p> <p>These failures could place residents under their care at risk for the transmission of communicable diseases and infections.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 01/28/2025 indicated Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses which included coronary artery disease (damage or disease in the heart's major blood vessels), peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), neurogenic bladder (condition that occurs when the nervous system's connection to the bladder is disrupted), diabetes, stroke, difficulty swallowing and hemiplegia (paralysis or weakness on one side).</p> <p>Record review of the quarterly MDS dated [DATE] noted Resident #1 did not have a BIMS score which indicated he had severely impaired cognition. The MDS indicated under section H0100 Resident #1 had an indwelling urinary catheter and under section M1040 diabetic foot ulcers.</p> <p>Record review of Resident #1's physician orders, dated 01/28/2025, indicated an order dated 08/07/2024 for EBP every shift, reason: indwelling catheter and wound. The orders indicated the resident had a suprapubic catheter and continuing treatments to an open wound to the left fifth toe.</p> <p>Record review of Resident #1's care plan, last reviewed 01/20/2025, EBP was not specifically indicated for his urinary catheter care.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 Resident #1's wound evaluation by the wound care physician on 01/20/2025 indicated a healing wound on the resident's left fifth toe measured 0.5 X 0.3 X 0.2 cm with moderate serous exudate (a thin, clear, or pale, yellow fluid that oozes from a wound during the inflammatory stage of healing).</p> <p>During an observation on 01/28/2025 at 8:20 AM, CNA A and Corporate Regional RN pulled Resident #1 up in bed without donning a gown. There were no containers with clean PPE products on the halls or nearby Resident #1's room. The door frame to his room had an orange magnet indicating EBP was to be used for the resident.</p> <p>During an interview on 01/28/2025 at 10:30 AM, CNA A said she knew Resident #1 had a urinary catheter and knew she was to don PPE of gown and gloves when providing direct care. She said they did not put on gowns. She said 2 weeks ago she put a 3 drawer plastic container on the second floor north hall filled with PPE. She said she did not know where it was now. She said there were no containers with PPE on the north unit and there were orange stickers all over the place. She said orange magnets are placed on the door frames and marked with an A or B indicating which resident required EBP.</p> <p>During an interview on 01/28/2025 at 10:35 AM the corporate Regional RN said there should be plastic 3 drawer cabinets on each hall containing PPE. She said she did not don a gown when assisting with pulling Resident #1 up in bed.</p> <p>2. Record review of a face sheet dated 01/28/2025 indicated Resident #2 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses which included Alzheimer's disease, difficulty swallowing, esophageal varices (abnormal veins in the tube running from the throat to the stomach) with bleeding, high blood pressure, and atrial fibrillation (ineffective pumping of the upper heart chambers).</p> <p>Record review of the quarterly MDS dated [DATE] noted Resident #2 had a BIMS score of 03 which indicated she had severely impaired cognition. The MDS indicated under section K020 the resident had a feeding tube present.</p> <p>Record review of Resident #2's physician orders, dated 01/28/2025, indicated an order dated 06/21/2024 for EBP every shift, reason: gastrostomy (feeding) tube.</p> <p>Record review of Resident #2's care plan, last reviewed 10/30/2024, EBP was not specifically indicated for her gastrostomy tube care.</p> <p>During an observation on 01/28/2025 at 8:35 AM there were no containers with clean PPE products on the halls or nearby Resident #2's room. The door frame to her room had an orange magnet indicating EBP was to be used for the resident.</p> <p>3. Record review of a face sheet dated 01/28/2025 indicated Resident #3 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses which included cerebral palsy, obstructive and reflux uropathy (hindrance of normal urine flow), and quadriplegia.</p> <p>Record review of the significant change MDS dated [DATE] noted Resident #3 did not have a BIMS score calculated for the significant change The MDS indicated under section H0100 Resident #3 had an indwelling urinary catheter and under section K0520 had a feeding tube present.</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 Resident #3's physician orders, dated 01/28/2025, indicated an order dated 09/01/2024 for EBP every shift, reason: indwelling catheter, feeding tube, and wound. The orders indicated the resident had an indwelling urinary catheter, a PEG tube, and continuing treatments to an open wound to the penis.</p> <p>Record review of Resident #3's care plans, last reviewed 11/07/2024, EBP was not specifically indicated for his urinary catheter care, PEG tube care or wound care.</p> <p>Record review of Resident #3's wound evaluation by the wound care physician on 01/20/2025 indicated an open healing wound on the resident's penis measured 0.6 X 0.5 X 0.1 cm with moderate serous exudate (a thin, clear, or pale, yellow fluid that oozes from a wound during the inflammatory stage of healing).</p> <p>During an observation on 01/28/2025 at 9:40 AM there were no containers with clean PPE products on the halls or nearby Resident #3's room. The door frame to his room had an orange magnet indicating EBP was to be used for the resident.</p> <p>During an interview on 01/28/2025 at 9:45 AM LVN D said EBP was to be used with residents that had a Foley catheter, PEG tube, or a wound. She said a kit should be outside he door and the kits had a sign on them indicating they were for EBP. She said the kits contained, gowns, gloves, masks, hand sanitizer, Sani-wipes, and shoe covers. She said only gloves and gowns needed to be donned for EBP. She said an orange sticker or magnet was attached to the door frame indicating which bed required EBP. She said there was an ADON on each floor and they were responsible for putting out the kits on their floors.</p> <p>During an observation on 01/28/2025 at 9:52 AM, CNA E moved a mechanical lift into Resident #3's room. He was lying on his bed, dressed, with a mechanical lift sling under him. There was no EBP kit outside the door or just inside the room. CNA E told the resident she was going to get someone to help with his transfer to his power chair.</p> <p>During an observation on 01/28/2025 at 10:00 AM CNA E and CNA F prepared to transfer Resident #3. Both CNAs did not don gowns and gloves. CNA F did not touch the resident she only operated the mechanical lift. CNA E placed the resident's urinary catheter bag in his lap for the transfer, she guided the resident into his chair while CNA F was raising and lowering the lift. CNA F left the room after the transfer was complete. CNA E continued to make the resident comfortable. She placed the urinary collection bag on the footrest of the power chair, tucked the sling loops in beside the resident, and helped him put on his watch and glasses. She said if he would move his chair around to the bathroom she would help him brush his teeth. She was not wearing gloves or a gown during the transfer and handling of the urinary catheter collection bag. She followed the resident into the bathroom and donned gloves to help him with his teeth.</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 and interview on 01/28/2025 at 10:05 AM ADON B said she was in charge of infection control on the first floor. She said EBP was to be used with residents that had a catheter, G-tube (feeding), wound, or a PICC (thin flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart). She said the cart containing PPE for EBP were located at the end of each hall. She said a cart was put outside a door if the resident was on contact isolation or had an infection. She said the carts she made had an orange colored sign that explained EBP and what to wear. She said she was aware staff were not always donning gowns and gloves for EBP. She was asked to show where the carts were on her 3 halls on the first floor. Her office was next door to Resident #3's room. A plastic 3 drawer container was outside the door that had not been there previously during his transfer. ADON B said that was not one of her supply boxes. It had a white set of directions on top of the box for contact isolation which she removed from the box since Resident #3 was only on EBP. She said there were no other supply boxes on the first floor north hall where Residents #2 and #3 resided.</p> <p>During an interview on 01/28/2025 at 10:15 AM RN G said he moved a PPE supply box from the west hall on the first floor to outside Resident #3's room. He said the box had been being used on the west hall and was not needed anymore and he put it on the north hall. He said he did not know why a supply of PPE was not outside Resident #3's room prior to his putting the box there.</p> <p>During an interview on 01/28/2025 at 10:18 AM CNA E said she forgot to put on a gown to transfer Resident #3. At first she could not remember what enhanced barrier precautions meant but when cued she said she was familiar with it and knew residents with catheters, feeding tubes and wounds staff should wear a gown and gloves when giving direct care. She said she would have worn a gown and gloves if the supply box was outside the resident's room or close by. She said she was not apt to always go the far end of the hall to get a gown.</p> <p>During an observation and interview on 01/28/2025 at 10:20 AM ADON C said EBP means the resident had a urinary catheter, feeding tube, or wound and donning a gown and gloves when giving direct care might prevent the resident from getting an infection. He said he tried to keep 2 boxes of supplies on all 3 of his halls on the second floor. He said an orange sticker magnet was placed on the door frame with an A or B marked on it to indicate which resident required EBP. He said there were no supply boxes on the north hall where Resident #1 resided. He said he was currently working on an inservice to address the EBP issue and he kept typing into his computer and did not acknowledge any further questions.</p> <p>During an interview on 01/28/2025 at 10:45 AM the DON said the 2 ADONs are the infection preventionists for their individual floors. ADON B on first floor and ADON C on second floor. She said the facility had not totally integrated a good process for making sure the supply boxes were present and supplied on each hall of the facility.</p> <p>Record review of the facility's policy dated 04/01/2024 and titled Enhanced Barrier Precautions indicated the following: .2. Wounds and/or indwelling medical devices even if the resident is not known to be infected 3. High Contact Resident Care Activities: a. Dressing, b. Bathing/showering, c. Transferring, d. Providing Hygiene, e. Changing linens, f. Changing briefs or assisting with toileting, g. Device care or use: Central line, Urinary catheter, feeding tube, tracheostomy., h. Wound Care: any skin opening requiring a dressing (not for superficial wounds requiring an adhesive bandage, such as a skin tear or skin break), i. Providing Shower or Bathing . D. PPE and alcohol-based hand rub: should be readily accessible to staff. May use discretion in</p> <p>(continued on next page)</p> | | |

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