

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 02/15/2025
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695</p> <p>Based on interviews, observation and record review, the facility failed to maintain grooming and personal hygiene for 1 (Resident #2) of 1 resident reviewed for activities of daily living care.</p> <p>The facility failed to ensure grooming and personal hygiene care was provided to Resident #2 in a timely manner.</p> <p>This failure could place residents at risk for social isolation and a loss of dignity and self-worth.</p> <p>Findings included:</p> <p>Review of Resident #2's Face Sheet, dated 2/15/2025, revealed she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses to include: Unspecified fracture of right wrist and hand, subsequent encounter for fracture with routine healing, -fracture of unspecified carpal bone, right wrist, subsequent encounter for fracture, unspecified fracture of shaft of unspecified fibula, subsequent encounter for closed fracture with routine healing, displaced bicondylar fracture of left tibia, sepsis due to unspecified, staphylococcus, -pyogenic arthritis, unspecified, hypokalemia, anemia.</p> <p>Review of Resident # 2's ADL Plan of Care, dated 2/8/2025, revealed she had a self-care performance deficit. She was maximum assist with bathing /showers, and she was dependent on the staff for meeting emotional, intellectual, physical, and social needs, related to cognitive deficits. She had impaired mobility evidenced by generalized weakness. She had skin breakdown, at risk for/actual, pressure ulcer to coccyx, wound to be cleaned every shift (6am-2pm). Revealed Resident #2 interventions for ADL care to assist the resident to turn, reposition, bathing, and hygiene daily and to be assisted by CNAs and nurses', the problem was the nurses were not assisting with ADL 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676005
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview/observation on 2/15/2025 at 1:45 PM, Resident #2 said the aide was not giving her regular baths/showers. She said she was to be cleaned every day due to her wound on her butt, but she had not been cleaned yet for today. She asked, do you want to see?. Resident #2 proceeded to uncover herself and roll over to let the state surveyor see that she was saturated from urine and feces her dressing dated 2/13/2025 was saturated. She said, this is all the time, but I don't want to get anyone in trouble. She said the CNA 's would answer her call light and tell her they would come back, but most of the time, they did not come back, and that would leave her feeling dirty. Resident #2 said she had not been cleaned up for the day and it's almost 2:00 PM. Resident #2 said she went to the hospital the other day and was embarrassed because she was wet and dirty going to the hospital, but the lady taking her helped to get her clean before she went. Resident #2 said she really likes her CNA, but she has too many residents to care for besides her and she can't always be taken care of when needed.</p> <p>During an interview with CNA B on 2/15/2025 at 1:55PM she said, she was the only CNA on the hall and she was just getting to Resident #2., She said it was too much for one CNA and you could see the nurses don't help me, she said I normally go through and check every resident but today I had a lot on my mind and the nurses know Resident#2 needs her dressing changed so I thought they would have assisted but as you can see they didn't assist., but I know that is no excuse and I didn't let anyone know I needed assistance, when asked what should you do, she said I should have let someone know I was behind.</p> <p>During an interview on 2/15/2025 at 2:00PM, RN(A) said he was the nurse on the hall taking care of Resident #2. He said they have a wound care nurse who did all the treatments and wound care, but she wasn't here yet., He said if the wound becomes dirty then the floor nurse, which was him, would have to change the dressings. He said if a resident goes to the hospital, then it's the nurse's responsibility to make sure the resident was clean and ready for transport this failure could cause the resident possible Urinary Tract, skin break and dignity for the resident.</p> <p>During an interview on 2/15/2025 at 2:35 pm, the DON said that they were not short staffed, and the CNA/nurses should make sure residents were receiving ADL care., the DON said there was a charge nurse and floor nurse that could have assisted Resident #2 if they see that the 1 CNA was behind on ADL care and this was not acceptable for a resident to be saturated in urine which may cause urinary track infection, skin breakdown.</p> <p>During an interview on 2/15/2025 at 3:13PM with the Wound care Nurse, she said she was working the floor and has been for the past couple of days as a medication nurse. She stated when she works the floor, each nurse was responsible to make sure their treatment/wound care gets done.</p> <p>During an interview on 2/18/2025 at 1:37 PM with a confidential interviewee, she said, when she came to pick up Resident #2, she was dirty, saturated in urine and there was not a nurse to assist to ADL's therefore she had to clean the resident before transporting her to the hospital.</p> <p>Review of a policy titled Bathing Policy dated, revised 1/20/2023 Staff will provide bathing services for residents within standard practice guidelines.</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>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** 41695</p> <p>Based on observations, interviews, and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of Resident #1 reviewed for pharmacy services.</p> <p>The facility failed to ensure RN A did not leave Resident #1's medications at bedside.</p> <p>This failure could place residents at risk of not receiving medications as ordered by the physician.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 2/15/2025 indicated he was an [AGE] year-old male who admitted to the facility on [DATE]. He had multiple diagnoses which included abnormal coagulation (a condition that affects the body's ability to clot blood), gastrointestinal hemorrhage, delirium, acute osteomyelitis (a bone infection that develops rapidly and is characterized by inflammation and destruction of bone tissue), type 2 diabetes mellitus without complications, and hyperlipidemia (an abnormally high concentration of fats or lipids in the blood).</p> <p>Record review of Resident #1's Medication administration record indicated Resident #1, was to receive, Lantus Solostar U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen (insulin glargine, human recombinant analog) 20 Units/Units Subcutaneous at bedtime Blood Glucose Check Site Location.</p> <p>***Hold For Blood Sugar Less Than 100*** If Blood Sugar Less Than 60 Or Greater Than 400, Notify MD***</p> <p>Dx: Type 2 diabetes mellitus without complications Start Date:02/14/2025.</p> <p>Record review of Resident #1's BIMS assessment dated [DATE] revealed he had a score of 99 indicating that for his cognition 4 or more items were coded 0 because the individual chose not to answer or gave a nonsensical response.</p> <p>During an observation and interview on 2/15/2025 at 01:50 PM, Resident #1 was noted to be lying in bed with his eyes open and family member at bedside. An over-the-bed table was stationed across his bed and was noted to have an insulin pen lying on the table. Resident #1 responded to his name being called. Family members questioned the insulin pen being on the resident's table. The Resident was unable to give an account of how the pen got there. He said someone must have left it there. The family said when they arrived to visit it was on the table.</p> <p>During an interview with RN A on 2/15/2025 at 1:55 PM, he said she was the person responsible for administering Resident #1 his medications. He said he went into Resident #1's room to assist with ADLs, and he had the insulin [NAME] in his hand and laid it down on the table and forgot to pick it back up when he left out of the room. He said Resident #1 doesn't get insulin on his shift and it was another residents insulin. He admitted this was not what he was to do, he should have never taken another resident's medication into another resident's room.</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>During an interview with DON on 2/15/2025 at 2:35 PM, she said this should not be on a residents table and she instructed RN (A) to remove the insulin pen., She said no other resident's medication should be taken into another resident room nor should any nurse every leave any medication at the bedside. She said medications left at the bedside placed residents at risk for receiving the wrong medications or not receiving medications.</p> <p>Record review of the facility's policy dated 07/2022 and titled Medication Administration indicated the following:</p> <p>17. Administer medication as ordered .</p> <p>18. Observe resident consumption of medication</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695</p> <p>Based on observations, interviews, and record review, the facility failed to assure that Resident#1 received a therapeutic diet as prescribed by his physician.</p> <p>The facility did not ensure Resident #1 received his physician ordered reduced concentrated sweets diet.</p> <p>The failure could place residents at risk for increase in disease process and other negative outcomes, such as wound healing, decline in functioning.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet indicated he was an [AGE] year-old male who admitted to the facility on [DATE]. He had multiple diagnoses which included abnormal coagulation (a condition that affects the body's ability to clot blood), gastrointestinal hemorrhage, delirium, acute osteomyelitis (a bone infection that develops rapidly and is characterized by inflammation and destruction of bone tissue), type 2 diabetes mellitus without complications, and hyperlipidemia (an abnormally high concentration of fats or lipids in the blood)</p> <p>Record review of Resident#1's physicians orders indicated Reduced Concentrated Sweets (RCS) diet, (is a diet that limits sugar RCS diet limits the sugar).</p> <p>Record review of Resident #1's BIMS assessment dated [DATE] revealed he had a score of 99 indicating that for his cognition 4 or more items were coded 0 because the individual chose not to answer or gave a nonsensical response.</p> <p>During an observation and interview on 2/15/2025 at 01:50 PM, Resident #1 was noted to be lying in bed with his eyes open and family member at bedside. An over-the-bed table was stationed across his bed and lunch tray placed in front of him and on this lunch try were 6 packs of regular sugar. Resident #1 responded to his name being called. The family members questioned if he should he have all that sugar and regular dessert on his tray with him being a diabetic.</p> <p>During an interview on 2/15/2025 at 1:55PM CNA (A) stated she was not aware of Resident#1 having a diet restriction, she said he was a new resident to the facility.</p> <p>During an interview on 2/15/2025 at 2:30 pm the DON and RN(A) stated the family questioned the sugar on the residents' tray. The DON said he should not have that sugar. She said someone should have checked his tray before delivering it and taken the sugar off. RN (A) said it was his responsibility to check the tray and he missed it. The DON said that the dietary staff should have caught this because the diet slip clearly says RCS. Both the DON and RN(A) said too much sugar could cause people with diabetes to have their blood sugar levels spike, which can lead to serious health problems.</p> <p>Record review of the facility's policy dated August 1,2018 and titled Diet Orders.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy:</p> <p>It is the policy of this facility to ensure that dietary restrictions will be followed in accordance with physician's orders.</p> <p>Compliance Guidelines:</p> <ul style="list-style-type: none"> * The nurse will obtain and verify the physician's order for the dietary restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department and will be recorded on the medical record or other format as per facility protocol. * The food and nutrition department will be notified by facility communication methods of the dietary restriction. * The risks and benefits of the diet restriction will be explained to the resident and/or resident representative. <p>*RCS - low sugar, NCS</p>