STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676005	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Nursing & Rehabilitation Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 4 residents (Resident #2) reviewed for MDS assessment accuracy. Resident #2's MDS admission assessment dated [DATE] failed to indicate Resident #2 had a pressure wound. This failure could place residents at risk of not receiving adequate care and services to meet their needs. Findings included: Record review of a face sheet dated 6/17/25 indicated Resident #2 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: spinal stenosis (the narrowing of one or more spaces within the spinal canal), atherosclerotic heart disease (gradual buildup of plaque in the walls of the arteries), hypertension (high blood pressure), spondylosis (degeneration in the spine), dementia (a group of symptoms affecting memory, thinking and social abilities), diabetes mellitus (condition that happens when blood sugar is too high), hemiplegia (paralysis of one side of the body), and pressure ulcer (injury to the skin and the tissue below the skin that are due to pressure on the skin), of the sacral region (bottom of the spine). Record review of the admission MDS dated [DATE] indicated Resident #2 had a BIMS score of 3, indicating he had severely impaired cognition. Section M-skin conditions of the MDS did not indicate Resident #2 had a pressure wound. During an interview on 6/17/25 at 1:00 p.m. the DON stated she had been in the position since the first week of May this year. The DON stated that the former wound care nurse did not do her job, as they found out she had not been keeping the wound care report up to date and had not added Resident #2 to the report. The DON stated that was why the information was not on the MDS, as the MDS nurse used the wound report to complete the MDS. The DON stated all the wound information should have been put on the report, and on the MDS. During an interview on 6/18/25 at 9:56 a.m. the MDS nurse stated she had worked in the facility since November 2024. The MDS nurse stated she used the wound care report to gather information for the MDS. She stated Resident #2 was not on the skin report, and that was why his wound was not addressed on the MDS. The MDS nurse stated all wounds were to be identified on the MDS. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/25 at 10:01 a.m. the ADON stated she had worked in the facility for 4 years. The ADON stated the former wound care nurse did not keep the wound care log up to date. The ADON stated the MDS nurse used the information from the wound care report to complete the MDS. The ADON stated the wound care nurse did not take her job serious and was terminated in May of 2025. The ADON stated the wound care log should have been kept up to date, and the correct information entered into the MDS for Resident #2. Record review of a facility policy titled Resident Assessment, with a revision date of 1/12/2020 indicate the following: .Standard of Practice: It is the Standard of Care at this facility to conduct, initially and periodically, a comprehensive, accurate assessment of each resident's functional capacity utilizing the Minimum Data Set (MDS) according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to 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 1 of 2 staff (CNA A) observed for infection control. The facility failed to ensure CNA A performed hand hygiene between glove changes. These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings Include: During an observation on 6/18/25 at 1:20 p.m. CNA A performed incontinent care on Resident #1. CNA A performed hand hygiene and put on gloves. CNA A opened Resident #1's wet brief. CNA A cleaned Resident #1's lower abdominal area, inner thigh, vaginal area, left buttock, right buttock, and between her buttocks with disposable wipes. CNA A removed her gloves, did not perform hand hygiene, and put on a clean pair of gloves. CNA A put a clean brief on Resident #1, removed her gloves, did not perform hand hygiene, put on a clean pair of gloves, and assisted Resident #1 into a clean pair of pants. During an interview on 6/18/25 at 1:30 p.m. CNA A said hand hygiene should be performed before and after providing care for a resident, after touching anything contaminated, and between glove changes. CNA A said she did not perform hand hygiene between glove changes when performing incontinent care on Resident #1 because she was moving too fast. CNA A said the importance of hand hygiene was to prevent infections. During an interview on 6/18/25 at 1:46 p.m. the DON said she expected hand hygiene to be performed before putting on gloves, after removing gloves, after providing care, and when the hands were visibly soiled. The DON said the importance of hand hygiene was to prevent the spread of infection. Record review of the facility's Hand Hygiene for Staff and Residents policy revised February 2025 indicated, To reduce the spread of infection with proper hand hygiene. Proper hand hygiene technique is completed whenever hand hygiene is indicated. Hand hygiene is the most important component for preventing the spread of infection .Hand hygiene is done .After: A. contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B. resident contact .D. toileting or assisting others with toileting, or after personal grooming .H. removal of medical/surgical or utility gloves . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Perineal Care (the process of cleaning the genital and anal areas) policy revised April 2023 indicated, Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection .Perineal Care for Female: a. Assist resident to lie on their back with legs flexed at knees and spread apart .d. Wash labia majora (prominent folds of the skin that form the borders of the vulva (the external female genitals)). Use dominant hand to gently retract the labia from thigh. Use dominant hand to wash carefully in skinfolds. Wipe in direction from perineum to rectum .e. Gently separate labia with nondominant hand to expose the urethral meatus (the external opening of the urethra) and vaginal orifice (the opening of the vagina). With dominant hand wash downward from pubic area toward rectum in one smooth stroke .Dispose of gloves and used supplies and perform hand hygiene. Apply new gloves and place new brief and change linens as needed .