

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  11/25/2025
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)
F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 1 of 4 residents (Resident #1) reviewed for accurate medical records. The facility failed to ensure as of 10/20/25 Resident #1's WAR had been completed to reflect she had been receiving wound care to her BLE as ordered in October 2025. The facility failed to be able to identify the staff member who's initial in the EMR system were MP1 on Resident #1's WAR after it had been filled out for October 2025. These failures could place residents receiving wound care at risk for wound care to be done more often than ordered by the physician, for staff not being able to question or collaborate with the unidentified staff member, or for receiving inaccurate care or diagnoses due to lack of documentation. Findings included: Record review of the face sheet dated 10/20/25 indicated Resident #1 was a [AGE] year-old female re-admitted to the facility on [DATE] with diagnoses including diabetes, non-pressure chronic ulcers (persistent open wounds that do not heal within 6 weeks and are not caused by pressure) of the right and left lower legs, congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), hypertension (elevated blood pressure), and atrial fibrillation (a condition where the upper chambers of the hear beat irregularly and rapidly). Record review of the Quarterly MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS of 10 and was moderately cognitively impaired. The MDS indicated Resident #1 had open lesion(s) other than ulcer, rashes, or cuts with treatment in place of non-surgical dressing and application ointments/medications. Record review of the care plan last revised 9/5/25 indicated Resident #1 had actual impairment of skin integrity related to wound to the lower leg. Record review of the physician orders indicated Resident #1 had orders to cleanse BLE with normal saline or wound cleanser, apply Xeroform (petroleum wound dressing) to open areas, apply ABD pads to the sites, wrap with rolled gauze, and secure with tape starting 9/6/25. Record review of the WAR dated 10/20/25 indicated it was not signed off that Resident #1 had received her wound cared to her BLE on 10/1/25, 10/2/25, 10/3/25, 10/4/25, 10/6/25, 10/7/25, 10/8/25, 10/9/25, 10/10/25, 10/11/25, 10/12/25, 10/13/25, 10/14/24, 10/16/25, and 10/17/25. Record review of the WAR dated 10/21/25 indicated it was signed off that Resident #1 had received wound care by a staff member with the assigned initials MP1 on 10/1/25, 10/2/25, 10/3/25, 10/4/25, 10/13/25, 10/14/25, 10/16/25, and 10/17/25 and by at staff member with the assigned initials kb25 on 10/6/25, 10/7/25, 10/8/25, 10/9/25, 10/10/25, 10/11/25, and 10/12/25. During an interview on 10/21/25 at 11:46 a.m. the DON said the floor nurses, herself and the ADON performed wound care on the residents since the Treatment Nurse's status changed to PRN. The DON said she did not know who went back in and documented wound care being performed daily in October after the previous surveyor had printed the WAR on 10/20/25. The DON said it could not be proved the wound care was performed on the days not documented other than the nurse saying she worked that day. The DON said LVN A had come to her the other day (date not specified) asking for bigger xeroform as she was using approximately 9 xeroform per leg on Resident #1's legs. The DON said she would ask who documented on the WAR for Resident #1's wound care and how they were able to prove the wound care was performed. During an interview on 10/21/25 at 12:09 p.m. the DON said kb25 was LVN A. The DON said she spoke with LVN A who said she went back in Resident #1's chart this morning (10/21/25) and documented wound care being performed. The DON said that LVN A said she had to go back in to document the wound care because she forgot to go to the WAR and check it off. The DON said she did not know who the assigned initials MP1 belonged to. The DON said her assigned initials in the EMR were MP25. The DON said she pulled the facility staff list for the EMR and could not find any staff member with the initials MP1 assigned to them. During an interview on 10/21/25 at 1:26 p.m. LVN A said she floated between sides upstairs depending on who was off work. LVN A said the nurses were responsible for performing wound care. LVN A said she worked out of the TAR in the EMR and did not check the WAR. LVN A said she did go in this morning and checked off in the WAR that wound care was performed on Resident #1 on the days she had worked. LVN A said she normally documented performing wound care on the 24hr report. During an interview on 10/22/25 at 9:52 a.m. Resident #1 said she was treated good at the facility. Resident #1 said her legs had to be wrapped today. Resident #1 said staff at the facility performed wound care on her daily. Resident #1 said she did not have any concerns at the facility. During an interview on 10/22/25 at 10:21 a.m. LVN B said to know if a resident</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>Provide and implement an infection prevention and control program.</p> <p>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 (LVN B) viewed for infection control. The facility failed to ensure LVN B performed hand hygiene between glove changes while performing wound care on 10/22/25. These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. These failures could place residents receiving wound care at risk for wound care to be done more often than ordered by the physician, for staff not being able to question or collaborate with the unidentified staff member, or for receiving inaccurate care or diagnoses due to lack of documentation. Findings Include: 1. During an observation on 10/22/25 at 10:35 am LVN B performed wound care on Resident #1. Prior to starting wound care LVN B washed her hands, disinfected her workspace, and gathered all wound care supplies. LVN B washed her hands, put on clean gloves, and removed the dressing from Resident #1's RLE. LVN B removed her gloves, washed her hands, put on clean gloves, and then cleansed Resident #1's RLE with normal saline. LVN B removed her gloves, did not perform hand hygiene, put on clean gloves, applied cream to Resident #1's RLE, and then applied Xeroform (petroleum-based dressing) to the open areas on Resident #1's RLE. LVN B removed her gloves, did not perform hand hygiene, put on clean gloves, applied ABD pads, and wrapped Resident #1's RLE with rolled gauze. LVN B washed her hands, put on clean gloves, and removed the dressing from Resident #1's LLE. LVN B removed her gloves, washed her hands, put on clean gloves, and then cleaned Resident #1's LLE. LVN B removed her gloves, did not perform hand hygiene, put on clean gloves, and then applied cream to Resident #1's LLE. LVN B removed her gloves, did not perform hand hygiene, put on clean gloves, and applied Xeroform to Resident #1's LLE. LVN B removed her gloves, washed her hands, put on clean gloves, and applied ABD pads secured with rolled gauze to Resident #1's LLE. During an interview on 10/22/25 at 11:20 a.m. LVN B said hand hygiene should be performed prior to starting care, after removing soiled dressing (during wound care), and when wound care was completed. LVN B said, It just depends (she did not give specifics on what it depended on) if hand hygiene should be done with glove changes. LVN B said the importance of hand hygiene was infection control. During an interview on 10/22/25 at 12:54 p.m. the DON said she expected staff to perform hand hygiene before providing care, any time gloves were changed, and when hands were visibly soiled. The DON said the importance of proper hand hygiene was to prevent infection. Record review of the facility's Handwashing/Hand Hygiene policy last revised October 2023 indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene is indicate: immediately before touching a resident. after contact with blood, body fluids, or contaminated surfaces. before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal. Record review of the facility's Standard Precautions policy last revised September 2022 indicated, Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume all blood, body fluids secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Standard precautions include the following practices: 1. Hand Hygiene. b. Hand hygiene is performed with ABHR or soap and water. (1) before and after contact with the resident. (3) before moving from work on a soiled body sire to a clean body site on the same resident. (5) after removing gloves.</p>		