

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  12/30/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 0656</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 reviews, the facility failed to implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the residents' practicable physical, mental, and psychosocial well-being for 3 (Resident #1, Resident #2, and Resident #3) of 6 residents reviewed for care plans. The facility failed to implement person-centered care plans for areas triggered on the CAA (Care Area Assessment) with interventions within 21 days of admission for Resident #1, Resident #2 and Resident #3 to meet medical, nursing, mental and psychosocial needs. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings included: Record review of an undated face sheet revealed Resident #1 was an [AGE] year-old female admitted on [DATE] with the diagnoses of rheumatic mitral stenosis (the narrowing and stiffening of the heart's mitral valve, usually caused by damage from rheumatic fever), bipolar disorder (serious mental illness causing extreme shifts in mood, energy, and activity levels, from highs (mania/hypomania) to lows (depression), significantly affecting daily functioning, sleep, and thinking, and chronic kidney disease stage 4 (severe kidney damage, with kidneys functioning at only 15-29%). Record review of an admission MDS assessment dated [DATE] revealed Resident #1 had a BIMS of 10, which indicated moderate cognitive impairment. She required substantial assistance (helper provides over half the help) with ADLs. The MDS revealed the triggered care areas of cognitive loss/dementia, visual function, communication, ADLs function/rehab potential, urinary incontinence/indwelling catheter, psychological well-being, falls, nutritional status, dehydration fluid maintenance, pressure ulcer, psychotropic drug use and pain. Record review of the EHR on 12/30/2025 at 10:00 a.m. revealed no care plan was implemented for Resident #1. Record review of an undated face sheet revealed Resident #2 was a [AGE] year-old male admitted on [DATE] with the diagnoses of diabetes mellitus type 2 (a chronic condition where the body either doesn't make enough insulin or doesn't use insulin effectively (insulin resistance), leading to high blood sugar levels as glucose can't enter cells for energy), atrial fibrillation (the most common type of heart arrhythmia, an irregular heartbeat where the upper chambers quiver chaotically, causing the heart to beat too fast and irregularly, which can lead to fatigue, palpitations, dizziness, and significantly increases stroke risk), and chronic kidney disease (a progressive condition where kidneys gradually lose their ability to filter waste and fluids from the blood). Record review of an admission MDS assessment dated [DATE] revealed Resident #2 had a BIMS of 10, which indicated no cognitive impairment. Resident #2 required substantial assistance (helper provides over half the help) with ADLs. The MDS revealed the triggered care areas of ADLs function/rehab potential, urinary incontinence/indwelling catheter, psychological well-being, falls, nutritional status, pressure ulcer, and pain. Record review of the EHR on 12/30/2025 at 10:15 a.m. revealed no care plan was implemented for Resident #2. Record review of an undated face sheet revealed Resident #3 was a [AGE] year-old male admitted on [DATE] with the diagnoses of fractured femur (a break in the thighbone, the body's longest and strongest bone, typically caused by severe trauma like car accidents or falls), hypertension (high blood pressure), obesity (a complex disease defined as having excessive body fat). Record review of an admission MDS assessment dated [DATE] revealed Resident #3 had a BIMS of 07, which indicated moderate cognitive impairment. Resident #3 required supervision and set up for ADLs. The MDS revealed the triggered care areas of cognitive loss/dementia, ADLs function/rehab potential, urinary incontinence/indwelling catheter, psychological well-being, falls, nutritional status, pressure ulcer, pain, and return to community. Record review of the EHR on 12/30/2025 at 10:30 a.m. revealed no care plan was implemented for Resident #2. During an interview on 12/30/2025 at 1:00 p.m., the MDS Coordinator stated about 3 weeks prior there were two MDS nurses. One MDS nurse was responsible for the residents on the bottom floor and the skilled residents. He was responsible for the rest of the residents. He stated he was unsure why the previous MDS nurse had not completed the care plans for Resident #1, Resident #2, and Resident #3. He stated the guidelines in the RAI manual stated 14 calendar days to complete the admission MDS and 21 calendar days to complete the comprehensive care plan. He stated the care plan was important because if it were read by everyone, they would have a blueprint to resident centered care. During an interview on 12/30/2025 at 2:00 p.m., the DON stated it was important for all residents to have a care plan. She stated the care plan provided an individualized guide to resident care. She stated that without the care plan everyone received generalized</p>		