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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 01/21/2026 |
| 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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, 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 (Resident #1, Resident #2, and Resident #3) reviewed for infection control. The facility failed to ensure CNAs A and C wore PPE when providing ADL care to Residents #1 and 3 both were labeled for EBP with Blue name tagThe facility failed to ensure LVN D wore PPE when providing enteral feeding to Resident #2 had a blue name tag indicating EBP. These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirementsFindings included:In an observation on 1/21/2026 at approximately 9:35 AM, Residents #1, #2, and #3 had EBP signage in place which was indicated by a blue name tag on the resident's door with their name and PPE (Personal protective equipment) was noted at the entrance to the resident room. Record Review on 1/21/2026, Residents #1 had a physician's order dated 8/7/2025 (Enhanced Barrier Precautions (EBP) R/T widespread rash and other skin conditions) Record Review on 1/21/2026 Resident #2 had a physician's order dated 1/7/26 (Enhanced Barrier Precautions every shift Dx: peg-tub) Record Review on 1/21/2026 of Resident #3 had a physician's order dated 7/31/2025 Enhanced Barrier Precautions (EBP) related to other skin changes.During an observation on 1/21/2026, of EBP signage (Enhanced Barrier Precautions) stated: everyone MUST clean hands before and after leaving room, wear gloves and gown for the following residents: dressing, bathing/showering, transferring, changing linen, providing hygiene, changing briefs or assisting with toileting device care central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing) In an observation on 1/21/2026 at approximately 9:45 AM CNA A entered Resident #1's room to perform ADL care and did not sanitize her hands before entering and did not don (put on) a gown to perform the ADLs (doing a bed bath). In an observation on 1/21/2026 at approximately 10:00 AM CNA C entered Resident #3's room to perform ADL care and did not sanitize her hands before entering and did not don (put on) a gown to perform the ADLs (peri care)During an interview on 1/21/2026 at approximately 10:30 AM with CNA's A and C both stated they both failed to put on a gown to do ADLs with Residents. Both CNAs stated they had been trained on hire on- Enhanced Barrier Precautions. Both stated, I just forgot to put on PPE on while doing ADL care.During an interview on 1/21/2026 at 10:35 AM with the DON (who also observed CNA A and C, doing ADL care), admitted she will take care of this. She said, this was not ok and both CNAs should have PPE on as this could cause spread of infection.In an observation on 1/21/2026 at 12:00PM LVN D was observed in Resident #2's room doing an enteral feeding and not wearing a mask or gown. There was signage indicating EBP was to be used, and PPE was present at the room entrance area.In an interview on 1/21/2026 at 12:15 PM with LVN D she said, she did not notice that she had not put on a gown for Resident #2 but was aware of the EBP and what she should have done when doing care for the residents, she stated, The EBP signage stated: When providing care for Dressing,</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 - Some</p> | <p>bathing/Showering, transferring, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care any skin opening requiring a dressing. In an interview on 1/21/2026 at 12:30PM with the DON who was the IP (Infection Preventionist Nurse), she was able to state a potential negative outcome for failure to observe EBP on at-risk residents. She said, These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirements. In an interview on 1/21/2026 at 12:45 PM with the Administrator, DON and AIT, the DON said, All the staff in the building all been trained and retrained on EBP. All three were able to state a potential negative outcome for failure to observe EBP on at-risk residents. These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirements. Record Review of the EBP Enhanced Barrier Precautions Policy dated 4/1/2024 indicated, EBP employs targeted gown, and gloves use in addition to standard precaution during high contact residents care activities when contact precautions do not otherwise apply .</p> | | |