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	05/05/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 1 residents reviewed for care plans. (Resident #86) The facility failed to revise Resident #86's Care Plan to reflect person centered interventions for tracheostomy care. This failure could place residents at risk of not having their needs addressed by nursing staff. Findings included: Record review of Resident #86 admission record revealed an admitted [DATE] with diagnoses which includes Anemia, Dysphagia following cerebral infarction, chronic obstructive pulmonary disease, gastro-esophageal reflux disease without esophagitis, acute kidney failure, encounter for surgical aftercare following surgery on the digestive system. Record review of Resident #86s care plan dated 4/29/2025 revealed Resident #86 had no care area to address tracheostomy or respiratory Care. Record review of physician's order of Resident #86 dated 4/29/2025 had no orders for trach size., no replacement cannula in room, suction machine, no manual resuscitation bag no order for diet change: During an interview with MDS coordinator on 4/30/2025 at 9:45 AM stated she was responsible for initiating and updated the care plans. MDS Coordinator stated Resident #86 had a care plan initiated and revised on 3/11/2025 but it did not address tracheostomy care, she said she does not know how this was missed. During an interview with DON on 4/30/2025 at 10:30 AM said Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2025 at 2:15 PM the DON said she expected care plans to be updated quarterly and as needed. The DON said the importance of updating care plans was to communicate a resident's needs and to ensure any changes in the residents' needs were documented for staff to know how to properly care for each resident. Record review of the facility's Comprehensive Care Plans policy dated 7/2022 indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will describe at minimum the following: Resident specific interventions that reflect the resident's needs and preferences and align with the resident's culture identity, as indicated .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695 Based on observations, interviews, and record reviews the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene care for 3 of 19 residents (Resident #51, #44, and #86) reviewed for ADL care. The facility failed to ensure Resident #51 and #86 were provided with proper personal hygiene care. The facility failed to ensure showers were completed for Resident #44. This failure could place residents at risk of not receiving the care as needed and place them at higher risk for skin breakdown and to feel socially isolated and have a loss of dignity and self-worth. Findings included: 1.Resident #51 Record Review of Resident #51's Face Sheet, dated 4/30/2025, 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, and anemia. Record Review of Resident #51 MDS dated [DATE], revealed she had a BIMS of 99 indicating the resident is unable to complete the interview, she required complete care with ADL's Review of Resident # 51's ADL Plan of Care dated 4/30/2025, 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. During an observation on 4/29/2025 11:00 at AM Resident #51 call light was pushed for assistance and continue to remain unanswered at 12:00 noon waited for over an hour for incontinent care. 2. Resident #86 Record review of Resident #86 admission record revealed an admitted [DATE] with diagnoses which include:, Muscle weakness (generalized),- Cognitive communication deficit, Mixed irritable bowel syndrome, other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain, Spinal stenosis, lumbar region with neurogenic claudication. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation 4/29/2025 at 11:18 AM Resident #86 call light was on for assistance she said she had been waiting over an hour to receive incontinent care, at 11:30 am observed three staff entered and exited the room without assisting the resident with incontinent care, at 11:45 AM one staff turned off the call light and left the room at 12:15 pm resident received incontinent care. Record Review of Resident #86 MDS dated [DATE], revealed she had a BIMS of 14 indicating the resident that a person's cognitive abilities are intact, she needed assistance with ADL's due to here lack of mobility. Review of Resident # 86's ADL Plan of Care, dated 04/29/2025, revealed she was incontinent of bowel and bladder, she had a self-care deficit, with interventions: Remind resident to call when needing assistance, provide assistance with self-care as needed On 4/30/2025 the following was observed: *8:55 AM 4 call lights rooms 104,106,107 and 105 observed with Nurse at end of Hallway 1, CNA observed picking up breakfast trays. *9:06 AM MA C passed rooms with call lights on *9:10 AM RN B passed rooms with lights and did not stop. *10:05 AM all 4 call lights were still unanswered *10:15 AM all 4 call lights were still unanswered During an interview on 4/30/2025 at 11:00 AM with Resident #86 and family member both said the facility was slow to answer lights. During an interview on 4/30/2025 at 2:35 PM, the DON said a reasonable time for a resident to be changed after activating the call light was between five to twenty minutes. The DON stated if a nurse answered a resident's call light, If the resident requires two persons, get help. Or they can change the resident. If they're in the middle of med pass or something they can attempt to get a CNA. 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 Residents if they see that the CNA was behind on ADL care and this was not acceptable for a resident to have to wait over an hour for ADL care which may cause urinary tract infection, skin breakdown. The facility policy Call Lights: Accessibility and Timely Response (10/13/2022) read, in part, . All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. 3. Resident #44 Review of Resident #44's Face Sheet, dated 04/30/25, revealed a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, hyperlipidemia, unspecified, and anxiety disorder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 44's ADL Plan of Care, dated 09/30/2024, revealed she was occasionally incontinent of bladder. During an interview on 04/30/25 at 3:25 PM, ADON D said the shower logs for Resident #44 indicated she only received 1 shower for the month of April 2025. ADON D said, even though 1 shower was documented, she did not believe Resident #44 only received 1 shower for the month. She said she cannot prove Resident #44 received more than 1 shower for the month, rather, she believes this is a problem with documenting. Review of Resident #44's shower log on 04/30/25 at 3:47PM, for the month April, 2025, indicated, she received a shower on April 23, 2025. The shower log did not indicate a shower was provided to Resident #44 for any other date in April 2025. During an interview on 04/30/2025 at 3:55 PM, the RN, Regional Nurse Consultant said she was aware, that the shower log indicated Resident #44 only received 1 shower for the month of April 2025. She said it's a lack of documentation and she will correct it. Review of facility Policy and Procedure No: NSG-5.006 titled: Bathing (Not Partial or Complete Bed Bath), revised February 12, 2020. Standard of Practice: Staff will provide bathing services for residents within standard practice guidelines. 42190

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review, the facility failed to ensure that residents received care and services in accordance with professional standards of practice for 1 of 9 residents (Resident #1) reviewed for quality of care. 1. The facility failed to follow up with a cardiologist appointment on 2/25/25 for Resident #1 for 36 days, from 2/25/25 to 4/1/25. 2. The facility failed to ensure Resident #1 received a vascular surgeon referral when the order was given on 02/12/25, which resulted in the development of gas gangrene (rare but highly lethal and potentially life-threatening bacterial infection that destroys muscle tissue, blood cells, and blood vessels producing a gas that causes tissue death and a foul smell) and an above-the-knee amputation (surgical removal) of his right leg on 04/02/25. An immediate jeopardy (IJ) was identified on 05/04/25 at 11:00 AM. The IJ template was provided to the facility on [DATE] at 11:15 AM. While the IJ was removed on 05/05/25 at 5:32 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems on entering physician orders, scheduling appointments or referrals, and ensuring documentation of missed appointments. These failures could place residents at risk of receiving a delay in treatment or services, serious injury, harm, disfigurement, or death. The findings included: Resident review of Resident #1's face sheet printed on 4/11/25 indicated Resident #1 was an [AGE] year-old male who admitted on [DATE] and discharged on [DATE] and did not return. Record review of Admission MDS assessment dated [DATE] indicated Resident #1 had clear speech, was able to make self-understood and had the ability to understand others. He had BIMS score of 12 out of 15 indicating he was moderately impaired cognitively. The MDS assessment indicated Resident #1 did not exhibit rejection of care. The MDS assessment indicated Resident #1 required substantial to moderate assist with most ADLs. The MDS assessment indicated Resident #1 had no unhealed pressure ulcer/injuries, no venous and arterial ulcers present and no foot problems. Record review of Resident #1's revised care plan dated 01/31/25 revealed that the Resident #1 as being care planned for skin breakdown: At risk/actual. Related to: History of Cardiovascular Disease. Evidence By: Severe score 6-9 for Pressure Ulcer risk, Confined to bed and/or chair most of the time, extensive bed mobility and total transfer assist. Goal: Resident #1 would maintain clean and intact skin for the next 90 days. - Measures would be taken to prevent skin breakdown over the next 90 days and open area will be healed over the next 90 days. Interventions: -Assist Resident #1 to turn and reposition frequently. - Inspect skin daily with care and bathing and report any changes to charge nurse. - Keep skin clean, dry, and free of irritants. - Treatments and dressings as ordered per physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of after visit summary also known as the admitting orders printed on 1/24/25 indicated Resident #1 was in the hospital from 1/14/25 to 1/24/25 due to malignant hypertensive urgency (high blood pressure that requires treatment to bring it down). Follow up appointment with Cardiologist on Tuesday February 25, 2025, at 10:40am (arrive by 10:25am). Record review of an undated physician's orders report printed on 4/11/25 indicated Resident #1 had diagnoses including hypertensive urgency (a clinical situation in which blood pressure is very high with minimal or no symptoms, and no signs or symptoms indicating acute organ damage), unspecified skin changes, muscle weakness (generalized), unspecified diastolic (congestive) heart failure, and essential (primary) hypertension. The physician order's report further revealed the following treatment orders: 1. Dated: 02/06/25 to 02/25/25 - Cleanse right heel with normal saline, pat dry, apply xeroform, apply dry protective dressing, and wrap with Kerlex daily on the 6 AM - 2 PM shift. 2. Dated: 02/06/25 to 02/25/25 - Cleanse right great toe with normal saline, pat dry, apply xeroform, apply dry protective dressing, and wrap with Kerlex daily on the 6 AM - 2 PM shift. 3. Dated: 02/06/25 to 04/05/25 - Skin prep wipes twice daily to the right lateral ankle. 4. Dated 02/06/25 to 04/05/25 - Skin prep wipes twice daily to the right second toe. 5. Dated 02/06/25 to 04/05/25 - Skin prep wipes twice daily to the right lateral foot. 6. Dated 02/25/25 to 04/05/25 - Skin prep wipes twice daily to the right first toe. 7. Dated 02/25/25 to 04/05/25 - Skin prep wipes twice daily to the right heel. Record review of the wound care note, dated 02/06/25, reflected Resident #1 presented with wounds on his right heel, right distal lateral foot, right first toe, right second toe, and right proximal lateral foot. The exam portion reflected the wound care physician was unable to palpate the right pedal (foot) pulses. The recommendations included a right lower extremity arterial doppler. Record review of Resident #1's radiology report from a doppler scan, completed on 02/10/25, reflected The blood flow velocity (movement) is decreased in the arteries of the right lower extremity with a monophasic flow (decreased blood flow), likely moderate inflow disease (type of peripheral artery disease that refers to blockage in the arteries), outflow disease (refers to blockage in the lower extremity affecting the femoral artery and pedal (foot) vessels), and severe arterial disease (a vascular disorder that causes abnormal narrowing of arteries other than those that supply the heart or brain). Record review of the physician progress note, dated 02/12/25, reflected Resident #1 was seen in the facility. The progress note reflected Resident #1 had possible peripheral vascular disease (a vascular disorder that causes abnormal narrowing of arteries other than those that supply the heart or brain) and lower extremity wounds. The plan included Vascular Surgery referral. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the wound care note, dated and signed by the Wound Care Doctor on 02/17/25, reflected Resident #1 had a total of 5 wounds to his right foot. A deterioration of the arterial wound to his right first toe was documented. A Vascular Surgeon referral was recommended. The wounds and measurements as follows: 1. right heel measured 2 cm x 2.5 cm x not measurable due to the presence of dried fibrinous exudate. 2. right first toe measured 4 cm x 2 cm x not measurable due to the presence of nonviable tissues and necrosis. 3. right second toe measured 1 cm x 0.4 cm x not measurable due to the presence of nonviable tissue and necrosis. 4. right distal, lateral foot measured 1.7 cm x 1.5 cm x not measurable due to the presence of nonviable tissues and necrosis. 5. right proximal, lateral foot measured 0.5 cm x 0.5 cm x not measurable due to the presence of nonviable tissue and necrosis. Record review of the wound care note, dated and signed by the Wound Care Doctor on 02/24/25, reflected Resident #1 had a total of 5 wounds to his right foot and was awaiting vascular referral for pad with dry gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection). The wounds and measurements as follows: 1. right heel measured 2 cm x 2.5 cm x not measurable due to the presence of dried fibrinous exudate. 2. right first toe measured 4 cm x 2 cm x not measurable due to the presence of nonviable tissues and necrosis. 3. right second toe measured 1 cm x 0.4 cm x not measurable due to the presence of nonviable tissue and necrosis. 4. right distal, lateral foot measured 1.5 cm x 1.5 cm x not measurable due to the presence of nonviable tissues and necrosis. 5. right proximal, lateral foot measured 0.5 cm x 0.5 cm x not measurable due to the presence of nonviable tissue and necrosis. Record review of the wound care note, dated and signed by the Wound Care Doctor on 03/03/25, reflected Resident #1 had a total of 5 wounds to his right foot. The not reflected Resident #1's wound to his right distal lateral foot was not at goal. The note reflected Resident #1 was awaiting a vascular referral. The wounds and measurements as follows: 1. right heel measured 2 cm x 2.5 cm x not measurable due to the presence of dried fibrinous exudate. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. right first toe measured 4 cm x 2 cm x not measurable due to the presence of nonviable tissues and necrosis. 3. right second toe measured 0.8 cm x 0.4 cm x not measurable due to the presence of nonviable tissue and necrosis. 4. right distal, lateral foot measured 2 cm x 1.5 cm x not measurable due to the presence of nonviable tissues and necrosis. 5. right proximal, lateral foot measured 0.5 cm x 0.5 cm x not measurable due to the presence of nonviable tissue and necrosis. Record review of Resident #1's physician's telephone order dated 3/6/25 indicated an order for vascular consult referral for previous vascular issues. Diagnosis: Unspecified skin changes. Record review of the wound care note, dated and signed by the Wound Care Doctor on 03/10/25, reflected Resident #1 had a total of 4 wounds to his right foot. The note reflected Resident #1's wound to his right heel was not at goal. The note reflected Resident #1's wound to the right lateral distal foot was worsening. The note reflected Resident #1 was awaiting a vascular referral. The wounds and measurements as follows: 1. right heel measured 3 cm x 2.5 cm x not measurable due to the presence of dried fibrinous exudate. 2. right first toe measured 4 cm x 2 cm x not measurable due to the presence of nonviable tissues and necrosis. 3. right second toe was resolved. 4. right distal, lateral foot measured 4 cm x 1.5 cm x not measurable due to the presence of nonviable tissues and necrosis. 5. right proximal, lateral foot measured 0.5 cm x 0.5 cm x not measurable due to the presence of nonviable tissue and necrosis. Record review of the wound care note, dated and signed by the Wound Care Doctor on 03/17/25, reflected Resident #1 had a total of 4 wounds to his right foot. The note reflected Resident #1's wound to the right lateral distal foot and the right proximal lateral foot were worsening. The note reflected Per patient, saw vascular last week. Will check on note. The wounds and measurement as follows: 1. right heel measured 3 cm x 2.5 cm x not measurable due to the presence of dried fibrinous exudate. 2. right first toe measured 4 cm x 2 cm x not measurable due to the presence of nonviable tissues and necrosis. 3. right distal, lateral foot measured 6 cm x 4 cm x not measurable due to the presence of nonviable tissues and necrosis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. right proximal, lateral foot measured 1 cm x 1 cm x not measurable due to the presence of nonviable tissue and necrosis. Record review of the wound care note, dated and signed by the Wound Care Doctor on 03/24/25, reflected Resident #1 had a total of 4 wounds. The note reflected Resident #1's wound to the right first toe was worsening. The note reflected Resident #1 was to see vascular next week. The wounds and measurements as follows: 1. right heel measured 3 cm x 2.5 cm x not measurable due to the presence of dried fibrinous exudate. 2. right first toe measured 6 cm x 4 cm x not measurable due to the presence of nonviable tissues and necrosis. 3. right distal, lateral foot measured 6 cm x 4 cm x not measurable due to the presence of nonviable tissues and necrosis. 4. right proximal, lateral foot measured 1 cm x 1 cm x not measurable due to the presence of nonviable tissue and necrosis. Record review of the wound care note, dated and signed by the Wound Care Doctor on 03/31/25, reflected Resident #1 had a total of 4 wounds. The note reflected Resident #1 was awaiting a vascular referral. The wounds and measurements as follows: 1. right heel measured 3 cm x 2.5 cm x not measurable due to the presence of dried fibrinous exudate. 2. right first toe measured 6 cm x 4 cm x not measurable due to the presence of nonviable tissues and necrosis. 3. right distal, lateral foot measured 6 cm x 4 cm x not measurable due to the presence of nonviable tissues and necrosis. 4. right proximal, lateral foot measured 1 cm x 1 cm x not measurable due to the presence of nonviable tissue and necrosis. Record review of Resident #1's weekly wound report from 1/24/2025 to 4/11/2025 indicated he was treated by the treatment nurse on the following dates: 2/6/25, 2/10/25, 2/17/25, 2/14/25, and on 3/3/25. Record review of Resident #1's treatment administration records dated March 2025 and April 2025 indicated wound care to Resident #1's right first toe, right second toe, right heel, right lateral ankle, right lateral foot was last completed on 03/31/25. Record review of Resident #1 transfer form dated 4/1/25 indicated he was transferred to a local hospital for signs and symptoms of infections/fever and wound deterioration/treatment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1 hospitalist admission note dated 4/1/25 indicated Resident #1 was sent from local nursing home for gangrene foot. Also, indicated Resident #1 was very unkempt and very odorous smelling in general and had a very gangrenous mummified right foot. Record review of Resident #1 hospital vascular surgery note dated 4/2/25 indicated the following: Reason for Consultation: Right foot gangrene; History of present illness: [Resident #1] was an [AGE] year-old male with history of atrial fibrillation, hyperlipidemia, and hypertension who presented to the emergency department yesterday via ambulance from nursing home for right lower extremity wounds. It appeared that the wounds had been there for some time with extensive gangrene to right foot and lower leg . Vascular surgery was consulted for major amputation as right foot was not salvageable. [Resident #1] did not take any blood thinning medications. Record review of after visit summary printed on 4/8/25 indicated Resident #1 was in the hospital from 4/1/25 to 4/8/25 for above the knee amputation due to gangrene of the right foot. During an interview on 4/11/25 at 3:27pm, LVN L said that she was the admitting nurse for Resident #1 and responsible for entering his orders. She said that she had finished the new admission paperwork and entered the orders and appointments as outlined in the after-visit summary from the admitting hospitals. LVN L said that she was not very proficient with the new admission process and could not remember the admission paperwork for Resident #1. However, she said that if a cardiologist appointment was listed in the after-visit summary for Resident #1, it should have been recorded in the scheduler for the transportation driver. She indicated that the ADONs were responsible for reviewing the new admission orders and paperwork after the admission to ensure their accuracy. LVN L also said that the ADON on the second floor at that time was no longer employed there. During an interview on 4/14/25 at 3:34pm and at 5:54pm, DON O said she was unaware that Resident #1 had missed his cardiology appointment on 02/25/25, as well as the vascular appointment on 03/26/25, until the information was brought to her attention on 04/11/25. DON O stated the charge nurse assigned to the admitting resident's hall was responsible for entering the admission orders and scheduling the appointments in their system. During the morning meetings, department heads reviewed all new admissions from the previous day, and she did not know how the ball got dropped with Resident #1. DON O said she had access to the cardiologist's company system and was able to verify that Resident #1 indeed missed the appointment on 02/25/25, which was not rescheduled due to the failure to enter it at the time of admission, and the oversight was not identified until it was too late. DON O indicated Resident #1 maintained stable vital signs with no acute cardiac events of record and was followed by [their] in-house physician, NP and wound care doctor. She expressed her expectation was the Transportation Driver would have taken Resident #1 to the appointment on 03/26/25, as he was not a nursing staff member and was not qualified to make that decision. Additionally, she expected the nurse to document any missed appointments, reschedule them, and notify her, which had not occurred. DON O said she expected for the Treatment nurse to follow up on all orders given by the wound doctor because she was the only staff who had access to the wound doctor's notes. She said the Treatment nurse should be documenting on Resident #1's chart and followed up with Resident #1's vascular consult. (continued on next page)

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	676005	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Nursing & Rehabilitation Center	2450 E Fifth St Tyler, TX 75701

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/11/25 at 1:28pm, LVN L said that she was the charge nurse for [NAME] Hall and the left side of North Hall during the 6am-2pm shift. She indicated that Resident #1 was located on her hall and had a scheduled vascular surgeon appointment on an unspecified date in March 2025, which was missed because Transportation Driver P was impatient and refused to wait for CNA M to wash and clean Resident #1's face. LVN L said Resident #1 was positioned in a wheelchair near the nurse station, and when Transportation Driver P arrived to pick up Resident #1, CNA M was in the process of preparing to clean his face. At that moment, Transportation Driver P informed both her and CNA M that he did not have time to wait for the cleaning and subsequently decided it was too late to take Resident #1 to the appointment. LVN L attempted to explain to Transportation Driver P that most appointments typically allow a 15-minute grace period and expressed her belief that Resident #1 could have arrived on time since the appointment location was not far from the facility. However, Transportation Driver P dismissed her comments and left without taking Resident #1. LVN L mentioned she called to reschedule the appointment but was unable to provide a new date nor confirm the rescheduling had occurred, and she stated she did not document this information in Resident #1's chart. LVN L stated she did not remember informing anyone about Resident #1 missing the scheduled appointment and she should have documented it but failed to do so. During an interview on 4/11/25 at 1:35pm, CNA M said she worked as the NA for [NAME] Hall during the 6 am to 2 pm shift. She said Resident #1 resided on her hall and had a scheduled appointment on an unspecified date in March 2025. Resident #1 was unable to attend because Transportation Driver P refused to wait for her to clean Resident #1's face prior to the appointment. CNA M asserted the cleaning would not take long and communicated this to Transportation Driver P but, he determined it was too late to transport Resident #1 to the appointment. LVN L informed the driver Resident #1 still had sufficient time to arrive, but Transportation Driver P chose to walk away and instructed them to reschedule the appointment. CNA M stated she was unaware if Resident #1's appointment had been rescheduled. During an interview on 4/14/25 at 2:49pm, Transportation Driver P said he worked Monday-Friday from 7am to 3pm and rotated weekends since November 2024.He stated he received minimal on-the-job training when he first began his role. The limited training he did receive was from the previous driver he replaced, who provided instruction for approximately four days, after which he learned independently. Transportation Driver P recalled the incident involving Resident #1, LVN L, and CNA M. He stated on that morning, he had several back-to-back appointments. Due to the type of van, he operated, he could only transport one resident at a time if they were in a wheelchair, as that was the maximum capacity. He informed an unidentified nurse to ensure that Resident #1 was prepared for his appointment, given his busy schedule. Transportation Driver P could not recall the exact time, he attempted to pick up Resident #1 twice, but on both occasions, the resident was not ready. During the first attempt, Resident #1 was still in bed in his room, prompting him to notify the nurse to have the resident prepared for his return. After taking another resident to an appointment, he returned to the facility for Resident #1, only to find that CNA M had still not prepared him. He was informed they needed a few more minutes to clean Resident #1's face, but the process was taking longer than anticipated. When he returned to check on Resident #1 again, he found that the resident was still not ready. He then informed LVN L that Resident #1 would not make it to his appointment on time, as the time required to prepare the resident, transport him down the elevators, and secure him in the van would exceed the 15-minute grace period. Transportation Driver P stated that LVN L was responsible for rescheduling Resident #1's missed appointment, but he did not recall seeing a new appointment scheduled for the resident. He expressed that he did not believe the situation was his fault. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/14/25 at 6:21pm, the Treatment Nurse said that the wound doctor had instructed her to arrange an appointment for Resident #1 with the vascular specialist, which was her duty. She said the Vascular Consult was recorded on 3/6/25, and although she attempted to schedule the vascular appointments for Resident #1, her efforts were unsuccessful, and she failed to document those attempts in Resident #1's medical record. The Treatment Nurse could not clarify the reason for the 14-day delay between 3/6/25 and 3/20/25 in scheduling the vascular appointment. She said her last assessment of the Resident #1's wound occurred on Friday, 03/28/25, at which point there was no odor present, and Resident #1 had wounds located only on the right foot's side and heel, with indications that healing was taking place. Treatment nurse said herself and the wound doctor examined Resident #1's right foot the following Monday, 03/31/25, they detected an odor and noted a deterioration in the condition of the resident's wounds, which had begun to spread to the toes. She stated she only became aware of the situation on 3/31/25 when the Wound Doctor inquired about the outcome of Resident #1's vascular appointment scheduled for 3/26/25. Upon reviewing Resident #1's chart, she learned from an unidentified nurse that Resident #1 had missed the appointment due to transportation issues. The Treatment Nurse stated her responsibility to follow up on the wound doctor's orders, which she failed to do in this case. She did not reschedule the missed appointment because she was unaware of it until after the fact, and by the time she realized the oversight, Resident #1 was sent to the hospital the following day, 4/1/25. During an interview on 4/14/25 at 12:46pm, the Wound Care Doctor said Resident #1 had significantly inadequate blood flow, and the poor blood flow affected the healing, and the outcome of amputation might not have changed even with going to the appointment. During an observation and interview on 4/12/25 at 1:56pm, Resident #1 was at a different facility with an above-the-knee amputation on the right leg, accompanied by approximately 22 to 24 staples. He expressed no complaints or concerns regarding the previous facility. He mentioned feeling somewhat anxious at the hospital when informed about the impending loss of his leg, but he desired relief from pain and instructed the medical team to proceed with necessary actions. Resident #1 reported that he was free from pain. During an interview on 05/03/25 at 10:02 AM, CNA M stated she worked with Resident #1 regularly. CNA M stated Resident #1's wounds developed an odor prior to being sent to the hospital. CNA M stated she never saw the wounds because they were wrapped up most of the time. CNA M stated she had reported Resident #1's wound odor to multiple charge nurses and they handled it. CNA M was unable to remember when the odor started but stated it was approximately 1 week before he was sent to the hospital. During an interview on 05/03/25 at 10:22 AM, LVN L stated she did not recall any discoloration, edema, or wounds to Resident #1's legs when he admitted to the facility. LVN L stated she remembered Resident #1 developing a wound on his heel but was unable to remember the wound. LVN L stated on 04/01/25 CNA M reported that Resident #1 had an odor to his wounds. LVN L stated CNA M had reported she had told other nurses about the odor. LVN L stated Resident #1 was in therapy when CNA M reported the odor, so she requested Resident #1 be laid down after lunch so she could assess the wound. LVN L stated before she was able to assess Resident #1's wounds, LVN J and ADON D had assessed Resident #1 and sent him to the hospital for evaluation. LVN L stated she had not seen Resident #1's foot wounds for a couple of weeks because the Treatment Nurse was completing the treatments. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/03/25 at 11:01 AM, LVN J stated she was the treatment nurse at the facility. LVN J stated she completed treatments Monday through Friday unless she was working the floor. LVN J stated on the weekends and when she worked the floor the charge nurses were responsible for completing the treatments. LVN J stated on 02/06/25 she was alerted by therapy via a communication app that Resident #1 had some blisters to his right foot. LVN J stated the wound care doctor was in the facility, so she had him assess the wounds. LVN J stated the wound care doctor looked at the wounds, ordered treatments and an arterial doppler study. LVN J stated the wounds started off as fluid filled blisters than with treatment initiated, they started to dry out. LVN J stated the wounds appeared arterial or vascular from the beginning, which was why a doppler study was ordered. LVN J stated Resident #1 had no discoloration to his foot in the beginning. LVN J stated she was unaware Resident #1 had no palpable pedal pulses to his right foot, until she read the wound care doctors notes. LVN J stated she communicated the results of the doppler to the wound care doctor and he ordered a vascular surgeon referral. LVN J stated the DON had asked ADON Q to make the appointment, but he did not. LVN J stated after a few weeks had passed it was discovered that ADON Q had not made the appointment. LVN J stated she had made a few calls to attempt to schedule the appointment, but they had not gotten back to her, and she did not follow up. LVN J stated Resident #1's wounds started off as fluid-filled blisters, then dried and became black. LVN J stated Resident #1's feet were normal color and had no problems when he first admitted . LVN J stated LVN R reported Resident #1 had a deterioration of his wounds the day before he was sent to the hospital, but she was off and told her she would handle it tomorrow. LVN J stated pedal pulses were assessed each time the wound care doctor was at the facility. LVN J stated no pedal pulses to his right foot were able to be felt. LVN J stated the wound care doctor followed up with her every week regarding the vascular referral appointment and she would follow up with nursing management. LVN J stated Resident #1's right foot have no palpable pedal pulses, indicated there was no blood flow to that foot. LVN J stated when there was no blood flow, there was no blood circulation. LVN J stated complications of no blood flow to the foot or tissues included: hardening of the foot, increased risk of infection, and loss of limb. LVN J stated the vascular appointment and cardiologist appointment could have prevented the loss of his leg. LVN J stated she was responsible for following up with the wound care doctors' orders. LVN J stated she pulled an order report every day to review order changes for wounds. During an interview on 05/03/25 at 12:21 PM, the Wound Care Doctor stated Resident #1 presented with fluid-filled blisters to his right foot and there was no pulses present to the right foot. The Wound Care Doctor stated he believed it could have been arterial, so he ordered a doppler study. When the doppler study results were received he then ordered a vascular referral. The Wound Care Doctor stated he followed up with the referral status each time he was at the facility. The Wound Care Doctor stated the facility reported multiple issues which caused a delay in the appointment. The Wound Care Doctor stated Resident #1 had poor circulation from the first day he was treated, which was why the priority for his treatment was getting the Vascular Surgeon referral. The Wound Care Doctor stated his main goals for his wound care was to prevent infection and keep it dry and scabbed over. The Wound Care Doctor stated complication of residents with vascular disease and wounds included: the wounds would not heal, the wounds were more prone to infection, and the wounds would have progressively worsened, which could lead to gangrene. (continued on next page)

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	676005	A. Building B. Wing	05/05/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/03/25 at 1:01 PM, ADON Q stated he worked at the facility until March 2025. ADON Q stated he was the ADON at the facility. ADON Q stated he was unable to remember Resident #1 or anything to do with his care. ADON Q stated if a new admission arrived at the facility with a referral or an appointment the charge nurse would have looked at the paperwork and then placed it in the DON's box for review. ADON Q stated the Treatment Nurse was responsible for making the appointments or referrals requested from the Wound Care Doctor. ADON Q stated he was not involved in the wound care processes. ADON Q stated if a referral or specialist appointment was wound related LVN J would have made the appointment. During an interview on 05/03/25 at 2:12 PM, LVN R stated she had noticed a decline in Resident #1's wounds the day before he was sent to the hospital, which was a weekend. LVN R stated LVN J was at the facility brining some treatment supplies, when she notified her that Resident #1's wound looked worse and had an odor. LVN R stated LVN J stated she would assess the wound tomorrow during her normal working hours. LVN R stated she did not report the wound decline or odor to the doctor but thought the treatment nurse would have handled it. Record review of revised physician order policy dated 1/12/20 indicated, Policy: 1. The licensed nurse will receive and transcribe the physician's orders according to Practice Guidelines. 2. The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician . Record review of an undated DON O job description indicated, .Job Summary: The Director of Nursing position is to direct the provision of nursing services to facility residents. DON O will oversee the development and implementation of resident care plans and assure the provision of the best available quality of care for facility residents. Key Responsibilities (list specific job duties): A. Maintains appropriate nursing service obligations, goals, and standards of nursing practices consistent with licensure requirements and the Nurse Practice Act. B. Oversees, directs, and coordinates nursing staff to provide proper resident care consistent with standard nursing practices. C. Participates in screening prospective residents as well as ongoing assessment of resident needs . Record review of an undated charge nurse job description indicated, .Job Summary: The Charge Nurse position participates in and oversees the assurance of the provision of resident care services consistent with accepted standards of care and as prescribed by the attending physician. This position also provides direct resident care and assigns duties to LVN's and/or Nursing Assistant as appropriate. Key Responsibilities (list specific job duties): A. Assure resident care according to accepted standards. B. Observes, assesses, and reports resident condition/changes and documents. C. Administers medication/treatments as prescribed. D. Receive, transcribe, implement physician's orders . This was determined to be an Immediate Jeopardy (IJ) on 05/04/25 at 11:00 AM. The Administrator and DON were notified. The Administrator was provided the IJ template on 05/04/25 at 11:15 AM. The following plan of removal submitted by the facility was accepted on 05/04/25 at 3:47 PM and includ[TRUNCATED]

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	676005	A. Building B. Wing	05/05/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences, for 1 of 1 residents (Resident #86) reviewed for respiratory care. The facility failed to ensure Resident #86 had a replacement trach at bed side, suction catheters and a sterile kit for suctioning at bedside and there was no manual resuscitation bag. These failures could affect residents who were dependent on respiratory care and could contribute to upper respiratory infections and worsening of their physical condition. Findings included: Record review of Resident #86's admission record revealed an admitted [DATE] with diagnoses which included: Acute respiratory failure, tracheostomy, unspecified whether with hypoxia or hypercapnia, Muscle weakness (generalized),-Dysphagia, oropharyngeal phase, and Cognitive communication deficit,. Record review of Resident #86's most recent quarterly MDS assessment, dated 4/29/2025 revealed a BIMS of 14 indicating the resident was cognitively intact for daily decision-making skills and did not reflect any respiratory therapies or treatments Record review of Resident #86's care plan, revision date 4/29/2025 did not reflect any need for respiratory care. Record review of Resident #86's physician orders for April 2025 revealed the following: *Trach Care - every shift; Suction trach as needed; Trach Care every Friday every AM shift (6AM -2PM); *Change Trach Trap: Trach Care as needed dislodged; Further review revealed there were no orders for Trach size. During an observation on 4/29/2025 at 11:04 AM, Resident #86 was sitting up in bed. Resident #86's oxygen concentrator was on with nasal canula tubing was lying on resident's chest, resident requesting nasal cannula be repositioned, tracheostomy tube was capped. There was not a replacement trach at bed side nor suction catheters and sterile kit for suctioning at bedside and no manual resuscitation bag. During an interview 4/29/2025 at 12:00 PM with Regional Nurse Consultant she said that anyone with a trach should have a replacement trach at bed side, suction catheters and canister, oxygen mask and manual resuscitation bag, sterile kit for suctioning at bedside. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 4/29/2025 at 12:30 PM RN B said anyone with a trach should have a replacement trach at bed side, suction catheters and canister, oxygen mask and manual resuscitation bag, sterile kit for suctioning at bedside, he said resident was capped but that was no excuse since she still has a tracheostomy. Record Review of facility Policy No: NSG-5.182 titled: Tracheostomy Care revised 2/12/2020 indicated emergency sterile tracheostomy equipment of the correct size will be kept at the bedside including the following: Replacement inner cannula, One tube of same and one smaller, Suction catheters (tracheal and oral), Suction machine and canister, Manual resuscitation bag, and Oxygen mask.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47723 Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 27 residents (Resident #11) and 1 of carts (first-floor east hall) reviewed for medication pass and storage. The facility failed to administered calcium carbonate 750 mg-simethicone 250 mg chewable tablet (calcium carbonate/simethicone) two tablets to Resident # 11 on 04/29/25. The facility failed to remove expired medications from the first-floor east hall nurse cart. These failures could place residents at risk for not receiving the intended therapeutic response of prescribed medications and not having accurate records of medication administration which could result in diminished health and well-being. Findings included: 1.During an observation of medication pass and interview on 04/29/2025 at 8:50AM MA H administered calcium carbonate 500mg 2 tablets crushed to Resident #11. MA H said Resident #11's medications were crushed per physician orders. A record review of Resident #11's physician orders indicated an order was written on 03/22/2024 for Resident #11 to receive calcium carbonate 750 mg-simethicone 250 mg chewable tablet, two tablets, chewable by mouth four times per day (two Tums) before meals and one at bedtime. During an interview on 04/30/2025 at 1:15 PM, MA H said the bottle of calcium carbonate 500mg was the 500 milligrams strength that were stored on both med-aide carts. MA H said she gave Resident #11 calcium carbonate 500mg 2 tablets crushed and documented it on the medication administrative record. She said she did not have calcium carbonate 750mg with simethicone 250 mg chewable tablets on the med-aide carts and did not know if the calcium carbonate 750mg with simethicone 250 mg chewable tablet was in the medication supply room or available in the facility. She stated she would go to the medication overflow supply room and notify the DON. During an interview on 04/29/2025 at 1:20 PM LVN K said, she did not know if calcium carbonate 750mg with simethicone 250mg chewable tablets were available in the medication carts or in the facility. She said the ADON, and the DON were responsible for transcribing physician orders in the MAR. 2.During an observation of the first-floor east hall nurse's medication cart and interview on 04/30/2025 at 1:30PM with LVN J the following was observed: -Resident #47 's Tylenol (Acetaminophen) 325mg tablets expired on 2/10/2025, and Melatonin 3 mg tablets expired on 2/06/2025. -Resident #50's ondansetron HCL 4mg tablets, expired on 03/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN J removed all three medications from the cart. She said expired or discontinued medication on the nurse's medication carts were reviewed every month and expired non-narcotic medications should be disposed of in the pharmacy's destruction bin. During an interview on 04/30/2025 at 2:30 PM, ADON D said she expected the MAs and the nurses to immediately remove from overflow stock and the medication carts medications that were outdated, contaminated, discontinued, or deteriorated according to procedures for medication disposal. During an Interview on 04/30/2025 at 3:39 PM, the DON said, the facility should have ordered the correct strength of calcium carbonate 750mg with simethicone 250mg chewable tablets. She said, after reviewing the physician order, the nursing staff should have called the physician to clarify the order, and notified the physician that the facility did not have the calcium carbonate 750mg with simethicone 250mg chewable tablets available at the facility. She said, the ADON and the DON were responsible for review and confirmation of medication orders for each individual resident on the MAR prior to administering medications. She said she expected the MAs and the nurses to immediately remove from stock any medications that were outdated, contaminated, discontinued, or deteriorated medications according to procedures for medication disposal. A record review of the facility's policy dated 01/12/2018, Revised 01/12/2020, and updated 01/2025, title Storage of Medication reference to #14. Outdated, contaminated, discontinued, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. A record review of the facility's policy effective 01/12/2028, revised 01/12/2020, and updated 012023, title Medication-Guidelines on Clinical Practice reference to administer oral medications in an organized, accurate and safe manner. And reference procedures #5. To review and confirm medication orders for each individual resident on the Medication Administration Record prior to administering medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140 Based on observations, interviews, and record reviews, 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 1 of 4 residents (Resident #95) reviewed for Enhanced Barrier Precautions. CNA G failed to don PPE while assisting Resident #95 to transfer to his bed and adjusting his urinary catheter drainage bag. This failure could place residents under their care at risk for the transmission of communicable diseases and infections. Findings included: Record review of a face sheet dated 04/28/2025 indicated Resident #95 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses which included bacteremia (condition where bacteria is in the blood stream), non-pressure chronic wounds to both feet, obstructive and reflux uropathy (obstructive is a condition where the normal flow of urine is blocked somewhere in the urinary tract and reflux involves urine flowing backward into the ureters and kidneys), prostate cancer, and diabetes. Record review of the initial MDS dated [DATE] noted Resident #95 had clear speech, had a BIMS score of 07 indicating he was severely cognitively impaired, was dependent for most ADLs, had an indwelling urinary catheter and was incontinent of bowel. The MDS indicated under section H0100 Resident #1 had an indwelling urinary catheter, under section M1040 diabetic foot ulcers, and under section O110 IV medications. Record review of Resident #95's physician orders, dated 04/28/2025, indicated an order dated 04/17/2025 for EBP every shift, reason: PICC line (peripherally inserted central catheter inserted into the upper arm to deliver medications and fluids directly into a large vein near the heart), wounds, and indwelling urinary catheter. The orders indicated the resident had orders for wound care on diabetic wounds on both feet. During an observation on 04/28/2025 at 1:46 PM, CNA G assisted Resident #95 to transfer from his wheelchair to his bed, moved his urinary catheter drainage bag from the wheelchair to the bedframe without donning a gown and donning only one glove she had in her pocket on her left hand. There was a container with clean PPE products outside of Resident #95's room. The door frame to his room had an orange magnet indicating EBP was to be used for the resident. During an interview on 04/28/2025 at 1:55 PM, CNA G said she knew Resident #95 had a urinary catheter, PICC line and wounds and knew she was to don PPE of gown and gloves when providing direct care. She said she was not expecting the resident to want to get into bed to eat his lunch and knew she was supposed to put on gown and gloves. She said she did not have a pair of gloves in her pocket, just the one that she put on her left hand. She used both hands to attach the urinary drainage bag to the bedframe and to adjust the resident's bed covers (continued on next page)

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	05/05/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2025 at 10:45 AM the DON said the 2 ADONs are the infection preventionists for their individual floors. She said residents requiring EBP had an orange-colored magnetic strip marked with an A or a B affixed to the doorframe. She said there were a few doors that had a red colored star marked with the words EBP because they had runout of the orange strips. She said all staff had been inserviced numerous times on EBP and the use of PPE. She said she had done spot checks with staff on all shifts quizzing them on their knowledge of the use of PPE for EBP. She said a physician order was written in the resident's record so it would alert the nurses to make sure EBP practices were being done. She said EBP was also placed on the CNAs point of care so they were also aware which residents required EBP. She said the 3 drawer plastic containers were present on each hall in the facility and the nurses were to make sure the containers were stocked. She said they tried to keep 2 containers on each hall. During an interview on 04/30/2025 at 11:00 AM ADON D said she was in charge of infection control on the first floor. She said EBP was to be used with residents that had a catheter, G-tube (feeding), wound, or a PICC (thin flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart). She said the cart containing PPE for EBP were located on each hall. She said she tried to have 2 on each hall. She said the carts she made had an orange-colored sign that explained EBP and what to wear. She said she assisted in training staff to utilize EBP correctly. She said there were orange-colored magnetic strips affixed to the doorframes marked with an A or B to indicate which resident was currently on EBP. Record review of the facility's policy dated 04/01/2024 and titled Enhanced Barrier Precautions indicated the following: .2. Wounds and/or indwelling medical devices even if the resident is not known to be infected 3. High Contact Resident Care Activities: a. Dressing, b. Bathing/showering, c. Transferring, d. Providing Hygiene, e. Changing linens, f. Changing briefs or assisting with toileting, g. Device care or use: Central line, Urinary catheter, feeding tube, tracheostomy., h. Wound Care: any skin opening requiring a dressing (not for superficial wounds requiring an adhesive bandage, such as a skin tear or skin break), i. Providing Shower or Bathing . D. PPE and alcohol-based hand rub: should be readily accessible to staff. May use discretion in placement of supplies.