

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 06/30/2026
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)		
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. Based on interviews and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 6 of 7 medication carts reviewed for pharmacy services [1st Floor MA Cart, 1st Floor Nurse West/North (Odd) Cart, 2nd Floor MA West/North (Odd) Cart, 2nd Floor MA East/North (Even) Cart, 2nd Floor Nurse West/North (Odd) Cart, 2nd Floor East/North (Even) Cart]). The facility failed to ensure the nursing staff responsible for the safekeeping of narcotics performed and documented change of shift narcotic counts for the 1st Floor MA Cart, 1st Floor Nurse West/North (Odd) Cart, 2nd Floor MA West/North (Odd) Cart, 2nd Floor MA East/North (Even) Cart, 2nd Floor Nurse West/North (Odd) Cart, and 2nd Floor East/North (Even) Cart. This failure could place residents at risk for loss of medications and possible drug diversion. Findings included: Observation and record review on 06/28/2026 of the medication carts and June 2026 Narcotic Drug Shift Count Sheets indicated there were multiple missing signatures indicating change of shift narcotic counts were not completed as required from 06/01/2026 through 06/27/2026. The count sheets indicated the carts were to be counted at the beginning and end of each shift. Missing signatures for 06/01/2026 through 06/27/2026 were as follows: 1st Floor MA cart:10pm-6am shift - 54 missing signatures 2pm-10pm shift - 6 missing signatures 1st Floor Nurse West/North (Odd) cart: 6am-6pm shift - 19 missing signatures 6pm-6am shift - 23 missing signatures 2nd Floor MA Cart West/North (Odd) cart:2pm-10am shift - 9 missing signatures 2nd Floor MA East/North (Even) cart :2pm-10pm shift - 5 missing signatures 10pm-6am shift - 23 missing signatures 2nd Floor Nurse West/North (Odd) cart:6am-2pm shift - 4 missing signatures 2pm-10pm shift - 8 missing signatures 10pm-6am shift - 7 missing signatures 2nd Floor Nurse East/North (Even) cart:6am-2pm shift - 52pm-10pm shift - 110pm-6am shift - 17 missing entries During an interview on 06/28/2026 at 01:15 PM, MA-L said change of shift narcotic counts were important for ensuring there were no missing or unaccounted for narcotics. She said the missing signatures indicated the change of shift narcotics counts were not done. During an interview 06/28/2026 at 01:30 PM, MA-P said there was no acceptable excuse for not performing change of shift narcotic counts. She said change of shift narcotic counts were supposed to be done by 2 staff persons, the nurse or medication aide coming on duty and the medication aide or nurse going off duty. She said the change of shift narcotic count was important for making sure there were no narcotics missing drugs. During an interview on 06/28/2026 at 01:37 PM, LVN-R said the task of performing change of shift narcotic counts was important for ensuring all narcotics are accounted for. She said the signatures on the narcotic count sheets were proof the change of shift count was done. During an interview on 06/28/2026 at 02:05 PM, the DON said she was responsible for ensuring change of shift narcotic counts were being done every shift. She said the purpose of narcotic counts between the oncoming and off-going medication (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aides and nurses was to ensure all narcotics were accounted for and to reduce the risk of misappropriation or unaccounted for narcotics. A review of the facility's policy dated 2007 and titled Controlled Medication Storage indicated the following: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal, state, and other applicable laws and regulations. 6. At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. The nursing care center may elect to count all controlled medications at shift change.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions for 1 of 1 facility kitchens. The facility failed to ensure 3 cans of beets and 1 box of soybean frying shortening were not on the pantry floor. The facility failed to ensure stainless steel steam table pans were not stacked wet. The facility failed to ensure DA A did not hand dry items placed on the drain rack at the 3-compartment sink to air dry. The facility failed to ensure the bulk sugar bin did not have a scoop laying inside the product. These failures could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During observations and interviews on 06/28/2026 of the kitchen the following was noted: *at 8:15 AM in the dry pantry 3- 6.5 lb. cans of beets and 1 partially used 35 lb. box of soybean frying shortening were being used to prop the pantry door open. DA A came into the pantry and began putting the cans on the shelves and the box of oil on the shelf in the pantry. She said the cans were on the floor because someone just did not want to put them where they belonged. *at 8:20 AM on the pan rack adjacent to the 3-compartment sink the following steam table pans were stacked wet: 4-half size stainless steel 6 deep 4-quarter size stainless steel 6 deep 1-half size stainless steel 8 deep 3-full size stainless steel 8 deep *at 8:25 AM [NAME] B came to the 3-compartment sink area and saw the pans that were stacked wet and took one of the pans and placed it at the 3-compartment sink to be re-washed. She made a general loud announcement to staff that the pans cannot be stacked wet. *at 8:30 AM the bulk sugar bin under the prep table had a plastic scoop left inside the product. During an observation and interview on 06/28/2026 at 11:30 AM DA A was observed hand drying items with a kitchen towel on the 3-compartment sink drain rack that had just been pulled from the sanitizer sink in the 3-compartment sink. DA A was stopped by the DM from drying the items after surveyor intervention, the DM said the cans in the pantry should not have been on the floor and the pans and items washed and sanitized at the 3-compartment sink need to air dry and not be stacked wet or hand dried. Review of the undated facility policy titled Food Storage indicated .2. All foods or food items not requiring refrigeration shall be stored at least six (6) inches above the floor and at least eighteen (18) inches from sprinkler heads, on shelves, racks, dollies or other surfaces which facilitate thorough cleaning, in a well-ventilated room, not subject to sewage or wastewater backflow or contamination by condensation, leakage, rodents, or vermin. All packaged food, canned foods, or food items stored shall be kept clean and dry at all times. Review of the facility policy titled Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment, dated October 1, 2018, indicated .9. Air dry all equipment and utensils after sanitizing. Handle clean and sanitized equipment and utensils and all single-service articles in a way that protects them from contamination.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary and comfortable environment for six (Residents #56, # 36, #27, #12, #73, and #71) of six residents reviewed for physical environment. The facility failed to maintain clean, sanitary, and safe conditions in rooms for Residents #56, #36, #27, #12, #73, and #71 to prevent accident hazards. Specifically, the facility allowed dirt and debris to accumulate on flooring, rugs, and floor signs, and improperly stored an extra bed in a resident room, creating a trip hazard. These failures could place residents at risk of living in an unsafe, unsanitary and uncomfortable environment. Findings included: 1. A record review of Resident #36's face sheet, dated 06/28/2026, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 had diagnoses of epilepsy, cerebral palsy, spastic hemiplegia (cerebral palsy or nerve condition that causes stiffness and weakness on one side of the body), convulsions, bipolar disorder (mood disorder), depression, and hypokalemia (low potassium). Review of Resident #36's MDS assessment, dated 4/30/2026, revealed the resident had a BIMS score of 3 which indicated severe cognitive impairment and wheelchair mobility assistance. Observation on 06/28/2026 at 8:10 a.m., Resident #36's room revealed the floor was poorly maintained, two floor tiles were missing, located next to bed on the right side. The floor appeared sticky with a visible accumulation of dirt, debris, and wax build-up along the surfaces. 2. A record review of Resident #56's face sheet, dated 06/28/2026, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included convulsions, autistic disorder, aphasia (neurological disorder that impairs your ability to speak), depressive disorder, essential hypertension (high blood pressure), and gastrostomy (feeding tube directly into the stomach). Review of Resident #56's MDS assessment, dated 3/19/2026, revealed the resident had a BIMS score of 0 which indicated severe cognitive impairment and wheelchair mobility assistance. Observation on 06/28/2026 at 8:15 a.m., of Resident #56's room revealed the floor was poorly maintained, the floor tiles appeared sticky with a visible accumulation of dirt, debris, and wax build-up along the surfaces. Additionally, significant scratching with embedded dirt were noted on the floor tiles directly beneath the resident's bed. 3. A record review of Resident #27's face sheet, dated 06/28/2026, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #27 had diagnoses which included encephalopathy (brain damage), HIV, cerebrovascular disease (conditions that affect the blood vessels and blood supply to the brain), nutritional deficiency, hyperlipidemia (high cholesterol), major depressive disorder, hypothyroidism, and hypertension (high blood pressure). Review of Resident #27's MDS assessment, dated 5/8/2026, revealed the resident had a BIMS score of 15 which indicated cognitive intact and independent mobility. Observation on 6/28/2026 at 8:30 a.m., of Resident #27's room revealed the floor was poorly maintained and covered with a sticky substance. Additionally, surveyors observed two unanchored area rugs in the resident's room: one 2' x 3' rug located next to the bed, and one 3' x 5' rug in front of the table. Observed Wet Floor caution signs in the middle of room with floor being dry. Observations on 6/28/2026 at 1:55 p.m., 6/29/2026 at 8:30 a.m., 6/29/2026 at 3:20 p.m., and 6/30/2026 at 8:45 a.m., Residents' #27, #56, and #36 room showed that the floors were completely dry, and 'Wet Floor' caution signs were placed in the center of the room. Room revealed that the floor showed dirt with wax built up and covered with sticky substance. 4. A record review of Resident #12's face sheet, dated 06/28/2026, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses of morbid obesity, chronic (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	combined systolic and diastolic heart failure, cellulitis (bacterial skin infection), chronic obstructive pulmonary disease (a progressive, incurable lung condition that limits airflow), paroxysmal atrial fibrillation (irregular heartbeats that start and stop on their own), hypertension (high blood pressure), anxiety disorder, antisocial personality disorder, and depression. Review of Resident #12's MDS assessment, dated 5/2/2026, revealed the resident had a BIMS score of 15 which indicated cognitively intact and independent wheelchair mobility. 5. A record review of Resident #73's face sheet, dated 06/28/2026, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #73 had diagnoses Alzheimer's disease, heart failure, malnutrition, hypothyroidism (thyroid doesn't produce enough hormone), delusional disorder, hypertension (high blood pressure), glaucoma (eye disease leads to progressive vision loss), and muscle weakness, insomnia, depression, and tachycardia (abnormally fast heart rate). Review of Resident #73's MDS assessment, dated 3/22/2026, revealed the resident had a BIMS score of 2 which indicated severe cognitive impairment and dependent wheelchair mobility. Observation on 6/28/2026 at 8:40 a.m., revealed a bed fall mat next to Resident #73 had dirt built up, with several worn spots, and torn with quarter size hole in top covering and foam. 6. A record review of Resident #71's face sheet, dated 06/28/2026, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #71 had diagnoses of dementia, cerebral infarction (stroke), type 2 diabetes, heart failure, carcinoma of prostate (cancer of the prostate), depression, insomnia, contractures, and muscle weakness. Review of Resident #71's MDS assessment, dated 4/9/2026, revealed the resident had a BIMS score of 4 which indicated severe cognitive impairment and some assistance wheelchair mobility. Observation on 6/28/2026 at 8:30 a.m. and 1:55 pm Room occupied by Residents #12, #73, and #71 revealed that the floor was poorly maintained and that the floors were completely dry, and 'Wet Floor' caution signs were placed in the center of the room. Room revealed that the floor showed dirt with wax built up and covered with sticky substance. Room had occupancy for four residents with five beds in room. Two of the 5 beds were not occupied and were unmade with one having headboard on mattress. Interview on 6/28/2026 at 2:00 p.m., CNA J stated that she was wondering about the extra, unaccounted-for bed currently located inside room occupied by Residents #12, #73, and #71. She indicated that she does not know the reason why the bed is in the room and could not recall the exact duration of time it has been left there, though she estimated it has likely been present for a few days. Stated at this time she had not reported it to anyone. Interview on 6/28/2026 at 2:24 p.m., the Maintenance Director stated that the facility does not maintain a dedicated storage area for beds because beds are not typically stored, noting that the building maintains an exact count of beds to match the number of rooms. Upon being informed of environmental findings, he expressed that he was unaware that room occupied by Residents #12, #73, and #71 contained five beds and explicitly clarified that rooms are not permitted to hold extra beds. He explained that Hospice providers sometimes move facility beds when bringing in their own specialized equipment, but noted staff are normally required to notify him to coordinate the removal of the extra bed. The Maintenance Director was unaware of how long the additional bed had been present in that room and emphasized that extra beds cannot be stored in occupied resident rooms. He stated that he was unaware that room occupied by Residents' #27, #56, and #36 had a missing floor tile. He stated that such issues should be identified during Angle Rounds (routine inspections conducted by department heads)-and reported to his department for repair. Record reviews of charts for Residents' #12, #71, and #73 showed that residents were not receiving hospice. Observation on 06/29/2026 at 8:30 a.m., room occupied by Residents #12, #73, and #71 showed that the floors were completely dry, and 'Wet Floor' caution signs were placed in the center of the room. Room occupied by Residents' #27, #56, and #36 revealed that the floor showed dirt with wax built up (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and covered with sticky substance. Interview conducted 6/29/2026 9:30 a.m., with ADON stated that the standard process for handling extra equipment requires staff to notify the Maintenance Director, who is responsible for removing the items and storing them in a dedicated storage room located on the first floor. ADON stated the notification process was to ensure the environment remains clear and free of trip hazards for safety. She followed up by stating that any items that needed to be fixed should be reported to the maintenance director. Interview on 6/29/2026 10:20 a.m., LVN K stated that whenever maintenance issues arose or extra equipment was identified, she logged the information into the book located at the nurses' station. LVN K indicated that she would then contact the Maintenance Director regarding these matters. She stated that extra beds were not stored in residents' rooms. Observation on 06/29/2026 at 3:20 p.m., revealed in room occupied by Residents #56, #36, and #27 and room occupied by Residents #12, #73, and #71 that the 'Wet Floor' caution signs remained inside the rooms in the exact same positions as previously observed during the morning hours. However, the floors in both areas were completely dry at this time. Interview on 6/29/2026 at 3:30 p.m., the DON clarified that extra equipment, and wet floor signs were not supposed to be stored or left in resident rooms. She stated that staff should be notifying maintenance to remove an extra bed to storage, and she acknowledged that leaving items in rooms could be harmful, creating trip hazards that could potentially cause resident injuries. Interview and observation on 6/30/2026 at 8:45 a.m., the Housekeeping Supervisor said regarding the continuous presence of wet floor signs observed in Residents #56, #36, and #27 room and Residents #12, #73, and #71 room. The supervisor stated that leaving the signs in the rooms could create a significant trip hazard. He acknowledged that this practice was unsafe because both rooms accommodated independent residents who were at risk of falling. Interview and observation on 6/30/2026 at 8:50 a.m., were conducted with the Maintenance Director regarding resident safety in Resident #27's room. Two throw rugs were identified on the floor by the residents' bed and table, causing a potential tripping hazard; these items were removed from the floor by staff during the observation. Additionally, when addressing environmental conditions in Resident #73's room, the Maintenance Director noted that the floor mat was not in good condition, stating that the nursing staff is responsible for evaluating nursing equipment and notifying the maintenance department when replacements are required. Interview on 6/30/2026 at 10:26 a.m., the DON stated that the nursing staff held the responsibility to review the condition of floor mats. She further clarified that nursing personnel were expected to determine if a fall mat required replacement due to wear and tear. Additionally, she noted that keeping floor mats in poor condition could cause safety issues for the residents. A record review of the facility's policy titled Maintenance Service, dated December 2025 indicated the following: Policy Statement Maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. Maintenance personnel shall follow established safety regulations to ensure safety and well-being of all concerned. A record review of the facility's policy titled LTC Housekeeping and Environmental Cleaning Policy. Policy Statement The facility should maintain a clean, sanitary, safe, and comfortable environment for residents, staff, visitors, and others in the long-term setting. Housekeeping and environmental cleaning practices shall support infection prevention, resident dignity, order control, fall prevention, and overall quality of life.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS discharge in facility tracking record was electronically transmitted to the CMS System within 14 days after completion for 1 of 1 resident (Resident #85) reviewed for discharge MDS assessments. The facility failed to transmit a discharge MDS assessment for Resident #85. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings include: Record review of a face sheet dated 06/30/2026 indicated Resident #85 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included sepsis (a life-threatening complication of infection), acute respiratory failure with hypoxia (a condition where the respiratory system fails to maintain adequate blood oxygen levels), hypovolemic shock (a life-threatening medical emergency caused by severe blood or fluid loss), type 2 diabetes, Obstructive sleep apnea (a chronic disorder where the upper airway repeatedly collapses during sleep, blocking airflow), hypocalcemia (abnormally low levels of calcium in the blood), rheumatoid arthritis (a chronic autoimmune disease where the immune system mistakenly attacks the lining of your joints), depression, anxiety, and hypertension. The face sheet indicated Resident #85 had a date of discharge to home of 02/02/2026 with a discharge status of no return anticipated. Record review of Resident #85's electronic medical record indicated there was a discharge MDS assessment completed on 2/2/2026 on record. However, the discharge MDS assessment was not transmitted electronically to CMS. During an interview on 06/29/2026 at 02:50 P.M. with the MDS Coordinator, he said he was responsible for completing the discharge MDS assessments and transmitting the discharge MDS assessment to CMS. He said the resident's discharge MDS assessment had been completed. However, he acknowledged he forgot to transmit the assessment to CMS and that it was missed. MDS Coordinator said it was important to complete and transmit the MDS assessments timely because they affect quality of care measures and payments. He said failure to complete and transmit discharge MDS assessments could result in inaccurate Quality Measures. During an interview on 06/29/2026 at 03:15 P.M., with the DON, she said admissions and discharges were discussed in the daily morning team meetings. She said they used the RAI Manual's schedule for completing and transmitting all MDS assessments. During an interview on 06/29/2026 at 03:22 P.M., the Admin., said the MDS LVN were responsible for completing the discharge MDS assessments. The Admin. said he expected the MDS Coordinators to complete and transmit the MDS assessments as scheduled and required by state and federal governing agencies. Record review of the CMS's RAI Version 3.0 Manual dated October 2023, Chapter 2:2-17, 2-37, and 2-44 indicated the following under required assessment summary: MDS Completion Date No Later Than discharge date +7 Calendar days. Transmission Date No Later Than discharge date +14 Calendar days.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screening for 1 of 5 residents reviewed for resident assessments (Residents #75). The facility failed to ensure Resident #75 had an accurate PASRR Level 1 Screening indicating a diagnosis of mental illness and refer the resident to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of a face sheet dated 06/29/2026 indicated Resident #75 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included depression (a mental disorder involving a depressed mood or loss of pleasure or interest in activities for long periods of time) and schizophrenia (a chronic mental health condition in which reality is interpreted abnormally and affects how the person thinks, feels, and behaves). Record review of a hospital Discharge summary dated [DATE] indicated Resident #75 had a diagnosis which included schizophrenia. Record review of the facility's physician's orders dated 05/29/2026 indicated Resident #75 had a diagnosis of schizophrenia and an order for Risperidone, an antipsychotic medication for the treatment of schizophrenia upon admission to the facility. Record review of an admission MDS assessment dated [DATE] reflected Resident #75 had a BIMS score of 12 indicating his cognition was moderately impaired. Further review of the admission MDS assessment indicated Resident #75 had a diagnosis of schizophrenia. Record review of Resident #75's PASRR Level 1 Screening completed by the hospital on [DATE] indicated in section C0100 there was no evidence of this individual having mental illness. During an interview on 06/29/2026 at 12:01 PM, the MDS Coordinator said he was responsible for tasks related to the PASRR and MDS processes. He said he was responsible for ensuring the PASRR Level I screening was accurate upon admission. He said he coded the admission MDS assessment for schizophrenia but did not catch that the PASRR Level 1 screening was incorrect. The MDS Coordinator said it was important to have correct PASRR Level I screenings to ensure residents were referred for PASRR Level II evaluations. He said the LA should have been made aware of the incorrect PASRR Level I screening. He said incorrect PASRR I screenings could result in a resident not receiving needed services. He said the facility used the RAI Version 3.0 Manual as the policy for completing PASRR tasks. A review of the October 2024 RAI 3.0 Manual: Chapter 3: Section A 1500 indicated the following: All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for a possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours for 1 of 5 residents (Resident #93) reviewed for care planning. The facility failed to develop a baseline care plan for Resident #93 within 48 hours of admission. This failure could place newly admitted residents at risk of delays in implementing individualized interventions necessary to address their immediate needs. The findings included: A record review of Resident #93's face sheet dated 06/28/2026 indicated a [AGE] year-old female admitted to the facility on [DATE]. Resident #93 had diagnoses which included Unspecified Viral Hepatitis C Without Hepatic Coma (a condition that causes inflammation of the liver), Anemia (a lack of healthy red blood cells which can cause fatigue, weakness, and shortness of breath), Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy Without Gangrene (a chronic condition where diabetes causes blood vessel damage in the extremities without tissue death), Hyperparathyroidism (a condition where the parathyroid glands produce too much parathyroid hormone leading to elevated calcium levels in the blood), End Stage Renal Disease (the final stage of chronic kidney disease where the kidneys can no longer function adequately to sustain life without treatment), Acquired Absence of Right Leg Above Knee (the permanent loss of the right leg at or above the knee joint) and Acquired Absence of Left Leg Above Knee (the permanent loss of the left leg at or above the knee joint). A record review on 06/28/2026 at 11:05 AM of Resident #93's electronic medical record revealed no evidence of a baseline care plan. Resident #93's electronic medical record indicated a completed Baseline Care Plan Acknowledgement dated 06/26/2026 at 4:00 PM signed by RN C which stated Resident #93 had been provided a copy of the baseline care plan. During an interview on 06/28/2026 at 12:45 PM, Resident #93 stated she was not aware of a baseline care plan and she did not receive a copy. During a telephone interview on 06/30/2026 at 8:29 AM, RN C stated she opened the baseline care plan but other disciplines had to complete their sections before it was finished. RN C stated she did not know why she would have signed that she provided Resident #93 with the baseline care plan if it was not completed. RN C stated she was not sure who was responsible to sign the baseline care plan to indicate it was completed. During an interview on 06/30/2026 at 9:17 AM, ADON D stated the admitting nurse was responsible for initiating the baseline care plan when a resident was admitted. ADON D stated SW was also able to initiate the baseline care plan. ADON D stated once the baseline care plan was initiated, each discipline completed their section and either the admitting nurse or the DON closed it. ADON D reviewed Resident #93's electronic medical record and stated there was no initiated baseline care plan for Resident #93. ADON D stated in the electronic medical record, the task for baseline care plan acknowledgement was produced prior to the initiation of the baseline care plan. ADON D stated typically the SW gave residents a copy of the baseline care plan. During an interview on 06/30/2026 at 9:30 AM, the SW stated when a resident was newly admitted the admitting nurse opened the baseline care plan and she completed the social services section. The SW stated she had completed Resident #93's baseline care plan on 06/29/2026. The SW stated Resident #93's baseline care plan was completed and it was probably just not closed. The SW reviewed Resident #93's electronic medical record and stated there was a baseline care plan initiated 06/30/2026 that was not completed. The SW stated she had not completed her section of the baseline care plan. The SW did not answer who was responsible for (continued on next page)		

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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.			
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiating the baseline care plan and stated Resident #93's baseline care plan was not available for her to complete when she checked for it. During an interview on 06/30/2026 at 10:18 AM, the DON stated the admitting nurse was responsible for initiating a baseline care plan. The DON stated when Resident #93 admitted on [DATE], it was a busy day and that was probably why it was missed. The DON stated typically on Monday morning, staff reviewed resident clinical information and that is when they might find any gaps in communication, but this did not occur due to the facility undergoing the annual relicensure/recertification survey. The DON stated she felt the risk to Resident #93 for not having a completed baseline care plan was low as staff met with her and her family on 06/26/2026 to discuss needs and discharge plans. The DON stated the overall risk to residents for not having a completed baseline care plan included things being missed or staff being unaware of the needs of residents. During an interview on 06/30/2026 at 11:06 AM, the ADM stated it was the MDS Coordinator's responsibility to initiate a baseline care plan when a resident was admitted. The ADM stated he was not sure why Resident #93 did not have a completed baseline care plan. The ADM stated the risk to residents for not having a completed baseline care plan included residents not being informed of their care. During an interview on 06/30/2026 at 11:14 AM, the MDS Coordinator stated he did not initiate or complete baseline care plans. The MDS Coordinator stated the admitting nurse completed baseline care plans. The MDS Coordinator stated he initiated Resident #93's baseline care plan because he saw it was missing, but typically he did not complete this task. A record review of Resident #93's undated baseline care plan indicated only that Resident #93 spoke English, had a code status of full code, and had no known allergies. A record review of facility policy dated March 2022 titled Care Plans - Baseline indicated the following: Policy StatementA baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and ImplementationThe baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following:Initial goals based on admission orders and discussion with the resident/representative;Physician orders;Dietary orders;Therapy services;Social services; and PASARR recommendation, if applicable. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 1 of 5 residents (Resident #57) reviewed for quality of life. The facility failed to ensure Resident #57 received nail care as observed on 06/28/2026, 06/29/2026, and 06/30/2026. This failure could place residents who are dependent on staff assistance at risk of not receiving care and services to meet their needs. The findings included: A record review of Resident #57's face sheet dated 06/29/2026 indicated an [AGE] year-old female admitted to the facility on [DATE]. Resident #57 had diagnoses which included Peripheral Vascular Disease (a circulatory condition where narrowed arteries reduce blood flow to the limbs, often causing pain or discomfort), Other Lack of Coordination, Muscle Weakness, Unsteadiness on Feet, Age-Related Physical Debility, Chronic Pain Syndrome, and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (a kidney complication resulting in damage to the kidney's filtering system). A record review of Resident #57's most recent Quarterly MDS dated [DATE] indicated Resident #57 had a BIMS of 15, which indicated intact cognitive function with minimal or no impairment. The MDS indicated Resident #57 was dependent on staff for showering/bathing, and required supervision or touching assistance for personal hygiene. A record review of Resident #57's comprehensive care plan most recently revised 06/05/2026 indicated Resident #57 had an ADL self-care performance deficit and interventions included check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care. Resident prefers to have longer nails and often refuses to have/allow nursing staff to perform appropriate nail care. The comprehensive care plan indicated Resident #57 had the potential for impairment to skin integrity and interventions included avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. During an observation and interview on 06/28/2026 at 9:30 AM, Resident #57 had fingernails extending beyond the fingertip on the first, second, and third digits of her right hand and all five digits on her left hand. Resident #57 stated she tried to keep her nails clean, but it was often difficult due to their length. During an observation and interview on 06/29/2026 at 8:34 AM, Resident #57 had fingernails extending beyond the fingertip on the first, second, and third digits of her right hand and all five digits of her left hand. Resident #57 stated she wanted them trimmed and that her pinky nail on her left hand was the longest. Resident #57 stated that it had been about a month since she got her nails trimmed, but it did not prevent her from eating or writing. Resident #57 stated her nails had gotten so long they would break off and it would hurt. During an observation and interview on 06/29/2026 at 9:08 AM, Resident #57's longest nail, the fifth digit of her left hand, extended 1.5 CM beyond her fingertip. Resident #57 stated she was scheduled for bathing on Tuesdays, Thursdays, and Saturdays. During an observation and interview on 06/30/2026 at 8:41 AM, Resident #57 had fingernails extending beyond the fingertip on the first, second, and third digits of her right hand and all five digits of her left hand. Resident #57 stated she had gotten a bath that morning and was not offered to have her fingernails trimmed by the CNA. Resident #57 stated when her nails broke they bled, but not enough to need a bandage. During an interview on 06/30/2026 at 8:45 AM, CNA E stated he had been instructed on performing nail care for dependent residents. CNA E stated prior to clipping nails he would check with the nurse in case the resident was diabetic or on blood thinners. CNA E stated a good time to trim nails was right after a resident showered. CNA E stated he had not trimmed any residents nails that day. CNA E confirmed he assisted Resident #57 with bathing that morning. CNA E observed Resident #57's fingernails and (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he did not and should have asked her if she wanted them trimmed. CNA E stated he was unsure if Resident #57 was care planned for nail care. CNA E stated that the risk to residents of not having appropriate nail care included scratching themselves. During an interview on 06/30/2026 at 9:06 AM, LVN F stated Resident #57's pinky fingernail on her left hand was really long, but they all needed to be trimmed. LVN F stated she expected CNA's to notify her if they had concerns with a residents nails being too long. LVN F stated she evaluated Resident #57 that morning and did not notice her fingernails. LVN F stated she was unsure if Resident #57 was care planned for nail care. LVN F stated she expected CNA's to notify the nurse so they can assist with nail care for Resident #57. LVN F stated the risk to residents for not having appropriate nail care included broken nails and the potential for scratching their skin. During an interview on 06/30/2026 at 9:23 AM, ADON D stated CNAs were supposed to provide nail care when they assist residents with showering or bathing, and if the resident was diabetic she expected the CNA to notify the nurse of their need for nail care. ADON D stated nursing staff should also be assessing nail length when obtaining blood sugar levels. ADON D stated Resident #57 would refuse nail care at times, but it should still have been offered. ADON D stated the risk to residents for not having appropriate nail care included broken nails and skin tears that could cause wounds in a diabetic resident. During an interview on 06/30/2026 at 10:16 AM, the DON stated she expected CNA's to assess residents nails and ask if they want them trimmed. The DON stated Resident #57 could be particular about her nails, but staff should be more diligent about ensuring she was offered nail care. The DON stated the risk to residents for not having appropriate nail care included skin breaks and scratches that could lead to infection. During an interview on 06/30/2026 at 11:08 AM, the ADM stated he expected staff to follow residents care plans and offer to trim their nails as necessary. The ADM stated it would not be sanitary for a resident to have long nails as they could get stuff under them. A record review of Skin Monitoring: Comprehensive CNA Shower Review indicated Resident #57 received a bath or shower on 06/27/2026, 06/25/2026, 06/16/2026, 06/11/2026, 06/09/2026, 06/06/2026, 06/04/2026, and 06/02/2026. None of the skin sheets indicated concerns with Resident #57's nails. A record review of the facility's policy titled Activities of Daily Living (ADL), Supporting revised March 2018 indicated the following: Policy Statement Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post their most recent survey of the facility in an area of the facility accessible to residents, and family members and legal representatives of residents. The facility also failed to have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request, in 1 of 1 facility reviewed for resident rights. 1. The facility failed to maintain the most recent standard survey results dated 4/4/2026 and 4/22/2026 inside the public survey binder.2. The facility failed to post the results of the most recent survey in a place readily accessible to residents, family members, and legal representatives. These failures could place residents at risk for not having access to current information regarding the facility's compliance with federal and state regulations, limiting their ability to make informed decisions and exercise their rights.The findings included: An observation on 06/29/2026 at 10:48 AM revealed the survey binder was located within the facility behind receptionist desk. Review of the binder indicated it did not include the results from the most recent standard surveys completed 04/4/2026 and 04/22/2026. During an interview on 06/30/2026 at 10:02 AM, the ADM indicated he was responsible for ensuring the survey binder was up to date. The ADM indicated he believed the most recent standard survey to be located within the binder. The ADM reviewed the survey binder and recognized the most recent standard survey was not located inside. When asked the ADM did not indicate any potential risk to residents if residents requested to review the survey results. The ADM indicated he understood it was a resident's right to review the most standard survey results without having to ask for them. During a confidential group interview at an undisclosed date and time, 2 confidential residents indicated they did not have access to the most recent standard survey results without asking receptionist. Record review of the facility's policy entitled Survey Results, Examination stated a copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post the daily nurse staffing data at the beginning of the shift, in a prominent place, and readily accessible to residents and visitors that included the facility name and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care for 12 of 14 days reviewed for nurse staffing data. The facility did not post the daily staffing on 06/17/2026, 06/18/2026, 06/19/2026, 06/20/2026, 06/21/2026, 06/22/2026, 06/23/2026, 06/24/2026, 06/25/2026, 06/26/2026, 06/27/2026, or 06/28/2026. This failure could place residents, their families, and facility visitors at risk of not having access to information regarding staffing data and facility census. The findings included: During an observation on 06/28/2026 at 7:53 AM, the staffing sheet located in the front lobby of the facility was dated 06/16/2026. During an observation on 06/28/2026 at 1:00 PM, the staffing sheet located in the front lobby of the facility was dated 06/28/2026. During a telephone interview on 06/30/2026 at 8:27 AM, RN C stated she was the RN in charge on 06/28/2026. RN C stated she had never been instructed to update posted nurse staffing information. RN C stated she had seen ADON D update the posted nurse staffing information in the past, but was not aware of any other staff member assigned to update this information on the weekends. During an interview on 06/30/2026 at 9:25 AM, ADON D stated she typically updated the posted nurse staffing information. ADON D stated she was off work the week prior and did not assign anybody to update the staffing information. ADON D stated in her absence the Staffing Coordinator would update the posted nurse staffing information, but she was also off work. ADON D stated the nurse staffing information is required to be posted daily. During a telephone interview on 06/30/2026 at 9:53 AM, RN G stated she was the weekend supervisor on 06/27/2026. RN G stated she was aware of the posted nurse staffing information but had never been instructed to update it. During an interview on 06/30/2026 at 10:12 AM, the DON stated the staffing coordinator usually updated the posted nurse staffing information. The DON stated on the weekends the weekend supervisor was responsible for ensuring the posted nurse staffing information is updated. The DON stated the weekend supervisors may not have been aware they should have been updating the posted nurse staffing information. The DON stated the information should be posted and residents should be able to know what staff are available for them. During an interview on 06/30/2026 at 10:25 AM, the Staffing Coordinator stated ADON D usually completed the nurse staffing information and she would ensure it was posted. The Staffing Coordinator stated she did not assign anybody to post the nurse staffing information in her absence. The Staffing Coordinator stated she thought the weekend supervisor was assigned to update the posted nurse staffing information on the weekend, but she was unsure if they had been told they were supposed to. The Staffing Coordinator stated the posted nurse staffing information should have been updated. During an interview on 06/30/2026 at 11:00 AM, the ADM stated he was not aware the posted nurse staffing information was not updated. The ADM stated the Staffing Coordinator usually posted the information, but she was off work that week. The ADM stated on the weekend the Staffing Coordinator would post those days and if anything changed the receptionist would update the posting. The ADM stated the posted nurse staffing information should have been updated. A record review of an undated facility policy titled Policy on Staffing Sheet Posting indicated the following: In nursing home and long-term care facilities, staffing sheet posting is a regulatory requirement under the federal F732 - Posted Nurse Staffing Information rule (483.35(i)). The policy ensures that residents, staff, and visitors can see up-to-date staffing data at all times. Required Information to Post Each day, the facility must post: Facility name Current date Midnight census Total number and actual hours worked by the following categories of licensed and unlicensed (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	nursing staff directly responsible for resident care per shift:Registered nurses (RNs)Licensed practical/vocational nurses (LPNs/LVNs)Certified nurse aides (CNAs).		