STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675915	A. Building B. Wing	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Care Center	121 Fm 971 Georgetown, TX 78626

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure the resident's right to be free from misappropriation of resident property for one of one controlled medication storage cabinet reviewed for misappropriation. The facility failed to prevent the misappropriation of an unknown number of controlled medications being stored for destruction. The medications and the Drug Destruction Log were discovered missing on 09/30/25. This failure could place residents at risk of misappropriation of property.Findings included: Review of the facility self-report dated 09/30/25 reflected in part, Medications from the drug destruction (some narcs) went missing - log for these medications also went missing. Review of a Drug Destruction Log Prescription Drug Inventory reflected the sheet was initiated on 09/30/25. The log reflected the five controlled medications that were left in the drawer when the previous log and unknown medications went missing. Review of the AD Hoc QAPI meeting sign in sheet, dated 09/30/25, reflected the ADM, DON, ADON H, ADON I, SSD, DFN, AD, HRC, CN, and MDSN attended the meeting. The MD participated by text. The facility initiated an investigation. Review of 14 employee drug screens reflected 12 employees tested negative for the 12 drugs listed. One employee tested positive for two drugs and a second employee tested positive for five drugs. Both staff provided proof of current prescriptions to rule out elicit use. During an interview on 10/01/25 at 9:11 AM, the ADM stated the current DON was suspended while the investigation regarding the missing medications was conducted. The ADM stated they performed drug testing on the DON, ADONs, nurses and med aides who had been in the facility recently but had a couple more people to test. ADON H stated initially the DON had the keys for the controlled drug storage but did not want to hold the keys, so they were kept in a drawer in the DON/ADON shared office. ADON H stated she currently had the keys on her person while the DON was out. She stated the cabinet drawer was kept locked and the office door had a keypad lock. ADON H stated one day last week, between 09/22/25 and 09/26/25, she did not remember which day, she put some discontinued narcotics in the drawer and straightened the medications cards, so they fit neatly in the drawer. She stated there were multiple cards of different medications for various residents but did not know how many as that information was recorded on the drug destruction log. ADON H stated, yesterday (09/30/25) as she walked in the front door, a nurse approached her with narcotics to put in the discontinued cabinet. She stated when she opened the cabinet drawer, all but one card and a few bottles of liquid medication were gone, and the drug inventory log was gone too. During an observation and interview on 10/01/25 at 10:23 AM, the DON office was observed, a black 2-drawer filing cabinet was in the corner of the room. The cabinet was secured to the wall with three visible brackets. There was one built in lock on one cabinet drawer and a padlock on each drawer. ADON H stated she had the key to the lock on cabinet, and the ADM had the key to the padlocks. ADON H stated the code to the lock on the office door had just been changed. ADON H stated the cabinet had been under a desk, but the desk was just moved to another office. During an interview on 10/02/24 at 9:21 AM, the CN stated it was her expectation that narcotics to be destroyed were kept in the locked cabinet in the DON office. She stated the meds were counted and signed by two nurses. A sticker from the medication label was placed on the log sheet and the quantity of medication was added to the log. The medication and log sheet were then locked in the drawer. She stated the DON was responsible for the key to the locked cabinet and now with a second lock on the drawers, the ADM was responsible for the second key. The CN stated it now required both the DON and the ADM to unlock the cabinet. During an interview on 10/02/25 at 11:17 AM, LVN E stated the process was discontinued controlled medications were taken off the medication cart and given to the DON or ADON when they did not have a DON in the building. She stated the medication was counted, both nurses signed the count sheet then the DON stored the medications. During an interview on 10/02/25 at 11:44 AM, CNA G stated she worked as both a CNA and a medication aide. She stated when controlled medications were discontinued, the DON was notified. The medications were counted and the count sheet signed by both staff. The DON then secured the medications. During a telephone interview on 10/02/25 at 12:04 PM, the DON stated she had worked at the facility for about a month. She stated she was not familiar with the policy for medication disposal at the facility as she had not reviewed all the facility policies. She stated she was told ADON H managed discontinued controlled medications, and she did not ask any questions. She stated the medications were supposed to be always double locked. She stated she was responsible for the keys to the locked medication storage. During an interview on 10/02/25 at 3:08 PM, ADON H stated after she discovered the medications were missing, she ran a report for discontinued controlled medications since the previous

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 2 residents reviewed for accidents and supervision. The facility failed to supervise Resident #1 when she exited the facility through a door at the end of a hallway, walked down eight steps, across the parking lot and two traffic lanes then on to the center median of the road on 09/01/25. The speed limit on the road was 40 MPH. The noncompliance was identified as PNC (Past non-compliance). The IJ (Immediate Jeopardy) began on 09/01/25 and ended on 09/03/25. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk of injuries and accidents.Findings included: Review of Resident #1's face sheet, printed on 10/01/25, reflected an [AGE] year-old female readmitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (brain dysfunction causing confusion or memory loss), age-related cognitive decline, cerebral infarction (stroke), and vascular dementia (cognitive impairment caused by impaired blood flow to the brain). Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 7 which indicated severely impaired cognition. Section E (Behavior) reflected no wandering or other behaviors. Section GG (Functional Abilities) reflected Resident #1 was able to walk 150 feet with supervision or touching assistance. Review of Resident #1's comprehensive care plan, dated 07/21/25, reflected entries for impaired cognition, risk for falls, self-care deficit, and others. There were no entries regarding elopement. Review of Resident #1's elopement assessment dated [DATE], reflected a score of 7 which indicated she was not at risk for elopement. Review of Resident #1's progress note dated 09/01/25 at 3:51 PM, written by LVN A, reflected, Res walked out of the premises through the 500 door, res stated hse[sic] was going to sons house, son was already in the building during the incident. Res is ok with no issues. [sic] Review of Resident #1's progress note dated 09/01/25 at 4:11 PM, written by LVN A, reflected, Event - Elopement/Attempted BP-124/75. T-98.0. P-79. R-18. BS-N/A. Door Exited: 500 How long missing: less 10minutes Where was the resident discovered: outside the premises Injuries: No. Cognition / Behavior at Time of Event: Cognitive Impairment, Wanders, Requires cueing, res was walking along the 200 and 500 halls as usual when the family came to visit and the staff could not locate where the res was, seconds later res was noted to have gone out through the 500 back door without any supervision. res redirected back to the facility and head to assessment done, no injuries or bruises noted. np, don/adon aware. Initial Treatment/New Orders: n/a . Resident Statement: ' I WAS GOING TO MY SON HOUSE' [sic]Review of a statement dated 09/01/25, written by LVN V, reflected LVN V saw Resident #1 walking, with her walker, on the 500-hall at 4:20 PM. They spoke briefly and LVN V continued towards the nurses station. Review of a statement dated 09/01/25, written by MA W, reflected MA W was on the 500-hall after a medication pass and saw Resident #1 and LVN V have a brief encounter in the hall. Review of a statement dated 09/01/25, written by HA X, reflected HA X went to open the front door for a visitor around 4:30 PM. The visitor pointed towards the road where a few people were gathered. HA X notified a nurse in case the resident was in need of medical attention. Review of an email dated 09/02/25 at 6:51 PM, written by the ADM, reflected in part, It appears that the alarms on the doors work some of the time and not all the time. The alarm automatically shuts off at 15 seconds and no one heard it even in the offices at the beginning of the hall. During an observation and interview on 10/01/25 at 10:12 AM, MW B stated the door alarms were wired into the fire panel near the nurse's station. He stated if the door was pushed, it would open, and the alarm would sound. He stated staff must enter the proper code to turn off the alarm. MW B opened the door at the far end of the 300-hall and the alarm made a very loud constant noise. Several staff were observed responding to the alarm. MW B entered a code into the keypad and the alarm went quiet. During an observation and attempted interview on 10/01/25 at 12:39 PM, Resident #1 was observed lying in her bed in the secured unit. She smiled and stated she liked it in her room. She did not engage in further conversation and did not answer if she remembered walking out of the building. During a telephone interview on 10/02/25 at 9:05 AM, the CN stated as part of the elopement prevention plan, anyone who was at high risk for elopement had care plan interventions in place and that information was available to nurses and aides. She stated prior to the elopement on 09/01/25, Resident #1 was not assessed as being at risk for elopement. During an interview on 10/02/25 at 10:22 AM, the MS stated he started working at the facility on 09/08/25, but he was aware of the elopement on 09/01/25. He stated the old door alarm used batteries, and the new