STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455727	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Village Healthcare and Rehabilitation	207 E Parkerville Rd Desoto, TX 75115

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observations, interviews, and record review the facility failed to ensure the resident has the right to reside and receive services in the facility with accommodation of resident needs and preferences for one (Resident #1) of five residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system was within reach of the Resident #1 lying in bed. This failure could place residents in the facility at risk of being unable to have a means of directly contacting caregivers. Findings included: A record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male with a BIMS score 00 of 15, indicating severe cognitive impairment. Resident #1 was originally admitted to the facility on [DATE], and readmitted on [DATE] with the diagnoses including, neurogenic bladder, multiple sclerosis, and hemiplegia or hemiparesis (Hemiplegia: paralysis of one side of the body) with left elbow, and left wrist contracture. The review further reflected the resident was totally dependent on staff for the ADL's (activity of daily living). A record review of Resident #1's Comprehensive Care Plan dated 11/27/24 reflected Focus. At risk for falls r/t MS, seizures, impaired mobility, nonverbal, incontinent. Goal. Will be free of falls through the review date. Interventions. Anticipate and meet needs. Be sure the call light is within reach and encourage to use it to call for assistance as needed. Observation and interview on 01/15/25 at 10:32 AM Resident#1 was lying in bed. Resident#1's call light was on top of the nightstand. LVN A entered the room and stated the call light was not within reach of Resident#1 and took the call light from the nightstand and clip it to Resident#1 blanket. Interview on 01/15/25 at 10:33 AM LVN A stated the call light should be within residents reach all the time, and the risk to the resident could be not getting help on time could be a fall and possible injury. LVN A stated it was the responsibility of all the staff to make sure the call light was within resident reach before exiting the room. (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: 455727	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Park Village Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 207 E Parkerville Rd Desoto, TX 75115	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/15/25 at 12:14 PM the DON stated the call-light should be always accessible to the resident, and it was the responsibility of all staff to make sure the call lights always within reach of the residents. The DON stated the risk to the residents, if they cannot reach the call light, they could not call for help, and they would not get the help they needed. Interview on 01/16/25 at 12:06 PM the Administrator stated his expectation from all the staff was for the call light to be within reach of the resident before living the room either attached to the bed or the resident. He stated the risk to residents, they would not be able to make their needs known, and their needs would not be addressed in timely manner. He stated the in service was done monthly on staff meeting to take care of fall. Review of the facility policy titled policy/Procedure-Nursing services. Section: Routine Procedures- Subject: Call Light/Bell, revised 05/2007 revealed It is the policy of (to provide the resident a means of communication with nursing staff . 5. Place the call device within resident's reach before leaving room.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview, and record review the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #1) of one resident reviewed for catheter care. The facility failed to ensure Resident #1's urine catheter drainage bag kept off the floor when Resident#1 was lying in bed. This failure could place residents at risk for urinary tract infections. Findings included: A record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male with a BIMS score 00 of 15, indicating severe cognitive impairment. Resident #1 was originally admitted to the facility on [DATE], and readmitted on [DATE] with the diagnoses including, neurogenic bladder (urinary bladder dysfunction cause by nervous system conditions), multiple sclerosis, and hemiplegia or hemiparesis (Hemiplegia: paralysis of one side of the body). The review further reflected the resident had an indwelling suprapubic catheter r/t neurogenic bladder and was totally dependent on staff for the ADL's (activity of daily living). A record review of Resident #1's Comprehensive Care Plan dated 11/27/24 reflected Focus: Has Indwelling Suprapubic Catheter r/t Neurogenic bladder. Goal: Will remain free from catheter-related trauma through the review date. Intervention: Catheter: Position catheter bag and tubing below the level of the bladder and away from entrance room door. Secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. Review of Resident #1's Physician Orders Report dated 12/11/24 reflected, Suprapubic catheter care every shift. Monitor s/p insertion site for s/s of skin breakdown, pain/discomfort ., catheter pulling causing tension. Observation on 01/15/25 at 10:32 AM revealed Resident#1 lying in bed, with the bed to the lowest position, and the foley catheter drainage bag hanging to the side of the bed and sitting on the floor. LVN A entered Resident#1 room noticed the foley catheter drainage bag on the floor and position Resident#1 bed to higher position to prevent the drainage bag from touching the floor. Interview on 01/15/25 at 10:33 AM, with LVN A revealed, she stated the urinary drainage bag was to be always kept hanging at the side of the bed bellow the resident bladder, and off the floor. LVN A stated Residnt#1 was a fall risk and the staff had to keep the bed at the lowest position. LVN A stated the risk to Resident#1 development of infection. Interview on 01/15/25 at 12:14 PM with the DON, she stated the foley catheter drainage bag should be to gravity, hoked to the bed frame to drain properly, and not touching the floor. She stated it could cause irritation, and development of infection to the resident. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/16/25 at 12:06 PM with the administrator, he stated the catheter was to be maintained below the level of the resident bladder, and off the floor. He stated the risk to resident development of infection. The administrator further stated the facility will figure out way to keep residents at fall risk bed at lowest position will preventing the foley catheter drainage bag from touching the floor. The facility's policy titled, Infection Control Policy/Procedure. Section: Resident Care. Subject: Catheter Care, Foley, revised July 2022, reflected, . 1. May secure the tubing with securement device PRN to prevent migration of catheter/friction/tension. 2. Keep tubing below level of bladder.

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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** 47690 Based on observations and interviews, 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 (Resident #2) of 5 residents reviewed for infection control LVN A failed to wear appropriate PPE when providing suprapubic catheter care for Resident #2 who supposed to be on EBP (Enhanced Barrier Precautions). This failure placed the residents at risk of exposure to possible infectious agents. Findings included: Record review of Resident #2's quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral palsy, neurogenic bladder, mild intellectual disabilities, and needs for assistance with personal care. Resident#2 has a BIMS score of 12/15 indicating moderate cognitive impairment. Her Functional Status reflected she was dependent on staff for toileting hygiene including suprapubic catheter exit site care. Record review of Resident #2's care plan, dated 10/19/24, reflected she has Indwelling Suprapubic Catheter: R/t Neurogenic Bladder Secondary to QUADRAPLEGIC (paralysis of all four limbs) CP (Cerebral Palsy). Record review of Resident #2's physician orders reflected an order dated 06/27/24:Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: wound, Indwelling medical device, infection and/or MDRO (Multi drug resistant organism) status. Observation on 01/16/25 at 08:47 AM LVN A prepared to provide care to Resident #2's suprapubic catheter . LVN A washed hands and donned gloves and provided care without donning a gown. There was no signage and no supplies outside or inside of the Resident#2's room for EBP. Interview on 01/16/25 at 09:14 AM LVN A stated Resident #2 has an indwelling medical device and there supposed to be a signage and required PPE supplies in front of Resident #2 room, indicating she was on EBP, and that staff were required to wear a gown and gloves when providing care for the resident. LVN A stated she just did not wear required PPE when she went to provide suprapubic exit site care for Resident#2. LVN A stated she had been working in the facility for few months and had in service on EBP during orientation. Interview on 01/16/25 at 09:30 AM the DON stated all residents with wounds, catheters, feeding tubes, etc. are placed in EBP to minimize the risk of spreading infections between residents. EBP required the use of a gown and gloves for all high contact care of the resident. She stated the risk of not adhering to the appropriate PPE requirements was spreading infections to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/16/25 at 12:06 PM the administrator stated there should be signage in front of the Resident#2 room, and the supplies. He stated staff should don and doff proper PPE for high resident contact care, including gown, and gloves. He stated the last in service on EBP was done in November 2024. Record review of LVN A's skills verification checklist dated 11/04/24 reflected she was competent in Peri-care-Foley catheter tubing care. Review of the facility's policy IPCP Standard and Transmission-Based Precaution, Revised March 2023, reflected: 3. Enhanced Barrier Precautions (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with (MDROs).