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	06/20/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for one (Hall 400) of three medication carts reviewed for pharmacy services. On 06/19/25, LVN A failed to ensure medication cart was locked when not being used at the nursing station on Hall 400. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversion. Findings included: Observation on 06/19/25 at 11:10 am revealed the medication cart was unlocked in front of the nurse's station. The drawers faced the hallway, and no staff was in sight. LVN A walked by the medication cart and pressed the lock closed and left 400 Hall with a resident. The medication cart was left unlocked for approximately 5 minutes and no residents and visitors were in the area at that time. Interview on 06/19/25 at 11:20 am, LVN-PRN B stated the medication cart should be locked when not in use because residents could take medications out of the cart and take the wrong medication. Interview on 06/19/25 at 12:10 pm, LVN A stated she had a resident that returned from dialysis and went to go check on the resident. LVN A stated she was taking a resident off of the hall, checked the cart, and locked it. LVN A stated she should have locked the cart when she walked away. Interview on 06/20/25 at 9:15 am, the DON stated the medication cart should be locked to prevent drug diversion and access to medications by residents. Record review of the facility's policy titled Care and Treatment/ Pharmacy revised July 2023 reflected: It is the policy of this facility to store all drugs and biological in locked compartments .The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. 1. The cook failed to sanitize the thermometer between checking breakfast food on 06/20/25. 2. The cook failed to check the temperature of the cinnamon rolls, biscuits and fried eggs before they were served to the residents, These deficient practices could affect residents who received meals and/or snacks from the facility's only kitchen by placing them at risk for cross contamination and other food-borne illnesses. Findings included: Observation on 06/20/25 at 6:48 am to 7:40 am, the [NAME] checked the temperature of the scrambled eggs and wiped the thermometer off with a rag that was seating on the cart beside her. The [NAME] checked the temperature of the oatmeal, grits, puree sausage and puree eggs and did not sanitize the thermometer between checking each item. The [NAME] did not check the temperatures of the cinnamon rolls, biscuits, and fried eggs before being served to the residents on the hallway. Interview on 06/20/25 at 7:40 am, the [NAME] stated she did not sanitize the thermometer between foods because she did not have alcohol swabs, and they were about to serve the residents in the dining hall. Interview on 06/20/25 at 7:55 am, the Dietary Manager stated alcohol swabs were supposed to be kept in the kitchen, and she left out of the kitchen and got some. Interview on 06/20/25 at 9:00 am, the Dietary Manager stated by not wiping the thermometer off with the alcohol swabs between food items could put residents at risk of bacteria and infection The Dietary Manager stated not checking the temperatures of the food could led to illness and death. Dietary Manager stated she was aware of bloody chicken that was served to a resident over the weekend and would be in servicing staff on checking temperatures before serving food. Interview on 06/20/25 at 9:15 am, the DON stated that not wiping the thermometer could cause cross contamination, and not checking the temperatures of the food could cause food to not be cooked all the way. Interview on 6/20/25 at 10:30 am Admin nodded yes and did not respond to risk to resident question. Record review of the facility's policy titled Dietary Services, revised October 2022 reflected: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Record review of Safe Food Handling | FDA , updated 03/05/24 ,reflected: Cook to the right temperature Color and texture are unreliable indicators of safety. Using a food thermometer is the only way to ensure the safety of meat, poultry, seafood, and egg products for all cooking methods. These foods must be cooked to a safe minimum internal temperature to destroy any harmful bacteria. Cook eggs until the yolk and white are firm. Only use recipes in which eggs are cooked or heated thoroughly. When cooking in a microwave oven, cover food, stir, and rotate for even cooking. If there is no turntable, rotate the dish by hand once or twice during cooking. Always allow standing time, which completes the cooking, before checking the internal temperature with a food thermometer.

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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. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 (Halls 100 and 400) of 3 halls reviewed for environmental concerns. 1. The facility failed to lock 2 Hoyer lifts , bed with mattress, bed frame in the hallway on 06/19/25 could be a fall risk and injury concern and issue for residents. 2. The facility failed to lock 1 Hoyer lift, bed frame and left pallet seating upright by the storage supply closet on 06/20/25 could be a fall risk and injury concern and issue for residents. This deficient practice could place residents at risk of falls, injuries, and decreased quality of life. The findings included: Observation on 06/19/25 at 10:40 am on hall 100 revealed there was an unlocked bed and unlocked bed frame on hall 100. Observation on 06/19/25 at 10:50 am on hall 400 revealed there was an unlocked Hoyer lift and unlocked bed frame. Interview on 06/19/25 between 1:00 pm to 1:40 pm, CNA D, CNA E and CNA F stated the nursing staff were responsible to lock and store the Hoyer lifts after being used. Observation on 06/20/25 at 8:00 am on Hall 100 revealed a pallet was seating up upright against the wall with two boxes on top on the side of the storage door, and a Hoyer lift, bed frame was left unlocked down the hall. Interview on 06/20/25 at 8:10 am, LVN C stated CNAs were responsible to lock the Hoyer lift and put it away. Interview on 06/20/25 at 9:15 am, the DON stated everyone was responsible to put the Hoyer lift up after it had been used. The DON stated the unlocked equipment in the hallway could be a fall risk and injury concern and issue for residents. Interview on 06/20/25 at 9:22 am, the Central Supplies Coordinator stated normally the Maintenance Director broke the boxes down and took the pallet outside. The Central Supply Coordinator stated residents were not in danger because most of the resident down the hall were in wheelchairs and residents were pushed down the hall by therapy or staff. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview over the phone on 06/20/25 at 8:32 AM, the Maintenance Director stated it would take a lot for a resident to move an unlocked frame or bed. The Maintenance Director stated he usually took the pallets and boxes out back after supplies were put up. Interview on 6/20/25 at 10:30 am Admin stated ok to the equipment being left unlocked in the hallway and if there were risk to the residents. Record review of facility admission packet, undated reflected, safe environment. You have a right to a safe, clean, comfortable and homelike environment .