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	10/01/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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
	455727	A. Building B. Wing	10/01/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse for 1 (Resident #2) of 5 residents reviewed for abuse.The facility failed to ensure Resident #2 was free from abuse when Resident #1 punched him on 09/09/25, causing Resident #2 to have a scratch on his nose.This failure could place residents at risk for severe and long-lasting impacts on physical, psychological, and emotional wellbeing.Findings included:Resident #2Record review of Resident #2's MDS Assessment, dated 09/04/2025, reflected the Resident#2 was a [AGE] year-old male who originally admitted to the facility on [DATE]. He had BIMS score of 5 indicating severe cognitive impairment. His diagnoses included Non-Alzheimer's Dementia (cognitive decline that is not caused by Alzheimer's disease), Cerebrovascular Accident (a medical term for a condition where there's a sudden interruption of blood flow to the brain, causing damage to brain tissue), and hemiplegia (a medical condition that causes paralysis or severe weakness on one side of the body) . Record review of Resident #2's care plan, Date Initiated: 12/13/2022 reflected the following:[Resident#2] demonstrated physical behaviors toward another Resident who would not move out the way so he could pass by in his wheelchair. 9/15/25 resident to resident altercation in a resident's room. Interventions dated 9/15/25 indicated for 1:1 monitoring ; Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document and ; Document observed behavior and attempted interventions. Interventions dated 12/13/2022 indicated for Psychiatric/Psychogeriatric consult as indicated, when becomes agitated; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Review of Resident #2's Progress Notes reflected the following:*9/15/2025 2:32pm - Upon entering resident's room the charge nurse observed the two resident's grabbing at each other and pulling each other's shirt. Residents immediately separated and placed on 1:1 observation, NP G, Administrator, RP, NP F notified, skin assessment completed, and resident assisted out of the room and to the front lobby. This entry was written by LVN A. 9/15/2025 7:08 pm SW communicated with psychiatrist. Psych visited the residents due to res-to-res allegations. One on one discontinued per psych. This entry was written by SW. Record review of Resident#2's Psychiatric Subsequent assessment dated [DATE] Reflected that Patient is a [AGE] year-old African American Male admitted to the facility on [DATE] for Long Term Care. Seen for follow up visit. Seen sitting in lobby, agreed to go to room to complete visit. Has history of depression and dementia. Resident seen today due to having a altercation with another resident. When asked what happened he reports going in another residents room due to being previous resident in the room, he went in to get deodorant that he thought he left in the room. States He just jumper silly, I have clothes still in the room and when I went in he was sleep, he jumped up and tried to hit me and missed then he grabbed my wheelchair and turned it over. Declines being threatened by other resident. He was not the aggressor. I will discontinue 1:1 at this time, staff to call this writer for any concerning behavior with patient. Depression: Patient endorses current symptoms of loss of interest and decreased concentration and denies symptoms of sad moods, fatigue, guilt, feelings of worthlessness, psychomotor agitation, psychomotor slowing and suicidal ideation/intent/plan and appetite change. Patient endorses history of sad moods. This entry was entered by NP D Resident #1Record review of Resident #1's MDS Assessment, dated 09/29/2025, Reflected the Resident #1 was a [AGE] year-old male who originally admitted to the facility on [DATE] and re admitted [DATE]. He had a BIMS score of 03, indicating severe cognitive impairment. His diagnoses included Non-Alzheimer's Dementia (cognitive decline that is not caused by Alzheimer's disease), Cerebrovascular Accident (a medical term for a condition where there's a sudden interruption of blood flow to the brain, causing damage to brain tissue), hemiplegia (a medical condition that causes paralysis or severe weakness on one side of the body). Record review of Resident #1's care plan, Date Initiated: 03/14/2024 Revised on: 09/15/2025 Reflected Potential to demonstrate physical behaviors r/t Anger, Dementia, Poor impulse control**** Resident noted to have altercation with brother in dining room and aggressive/trying to hit staff members/swinging at staff. 9/15/25- resident to resident altercation in resident's room. Interventions 9/15/25 1:1 monitoring Date Initiated: 09/15/2025 Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 09/15/2025 Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Date Initiated: 03/14/2024 Document observed behavior and attempted interventions. Date Initiated: 03/14/2024 Psychiatric/Psychogeriatric consult as indicated. Date Initiated: 03/14/2024 When