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	11/15/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 8 residents (Resident #2) reviewed had a change of condition.The facility staff failed to notify the designated representative and the NP of Resident #2 that she had been sexually abused by Resident #1.This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. Findings included:Record review of Resident #2's face sheet dated 11/15/25 reflected she was a [AGE] year-old female admitted into the facility 09/22/25 with a diagnosis of senile degeneration of brain (a general term for a decline in memory, thinking, and other cognitive abilities associated with aging). Record review of Resident #2's care plan dated 9/22/25 reflected ADL self-care performance deficit impaired mobility/cognition. Goal was to maintain current level of function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. Interventions were to converse with resident while providing care, explain all procedures before starting, promote dignity by ensuring privacy, staff will provide appropriate level of physical assistance with ADL's, encourage them to participate to the fullest extent possible. Record review of Resident #2's initial assessment MDS dated [DATE] reflected a BIMS score of 01 (Severe Cognitive Impairment).Record review of Resident #1's face sheet dated 11/15/25 reflected he was a [AGE] year-old male admitted into the facility 07/14/25 with diagnoses of brain compression (a serious condition caused by increased pressure within the skull that pushes the brain against its rigid covering) and Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #1's care plan dated 9/3/25 reflected a focus of elopement risk and significantly intrudes on the privacy or activities, the goal was to maintain safety and would not leave the facility. Interventions/tasks were to distract resident from wandering by activities, food, conversation, television, document wandering behavior, identify pattern of wandering determine if aimless or escapist, is resident looking for something or did the wondering indicate he needed more exercise. Focus was a potential to demonstrate physical and verbal aggressive behaviors/manic episodes. Goal was to demonstrate effective coping skills and would not harm self or others. Interventions/tasks were to assess and anticipate resident's needs such as food, thirst, toileting needs, comfort and body position, pain. Communication provides physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, encourage seeking out of staff members when agitated. When he becomes agitated, guide away from source of distress, engages calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. Record review of Resident #1's quarterly MDS dated [DATE] reflected he had a BIMS score of 09 (Moderately Cognitively Impaired).Record review of Resident #2 and Resident #1's progress notes revealed no documentation of the incident, no documentation of notification to doctor, and no documentation of notification to designated representative. On 11/13/25 the State Surveyor observed the video dated 11/5/25, on the facility monitor, the video revealed the following:At 08:03 AM, Resident #1 left the dining room with a food tray and walked back into the dining room. At 08:29 AM Resident #1 came out of the dining room again and threw a bag away and went back into the dining room. At 08:30 AM CNA-A went into the dining room and came out of the room with Resident #2 and took her down the hall. Resident #1 followed CNA-A and Resident #2 out of the dining room and down the hallway, he was holding a green piece of material in his hand. A few minutes later at 08:51 AM Resident #2 was brought back to the hallway across from the nurses' station. Resident #2 was sitting in the hall alone on a bench when Resident #1 went to the counter and stood there a few seconds and then walked over to Resident #2 turned around and kissed her on the top of her head.In a face-to-face interview with Resident #1 on 11/13/25 at 11:55 AM, he was asked about an incident between he and Resident #2, he responded I did not rape that woman. He stated he helped her change her dress and helped her put on another dress. Resident #1 did not respond to any other questions. In an attempted face to face interview with Resident #2 on 11/13/25 at 12:10 PM, she did not respond to any questions, she was dressed appropriately, and she smiled when investigator asked if she enjoyed her lunch. In a face-to-face interview with CNA-A on 11/14/25 at 6:29 AM, she stated on 11/05/25 she observed Resident #1 walking down the hallway with an adult brief and put it in the trash, she observed him return to the dining room and he closed the door. She stated that

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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)

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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 0600 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 residents were free from abuse and neglect for 2 of 8 residents (Resident #1 and Resident #2) reviewed for abuse and neglect.The facility failed to ensure there was no inappropriate sexual behavior between Resident #1 and Resident #2. Resident #1 was observed in the dining room by CNA-A massaging the breast of Resident #2.An Immediate Jeopardy (IJ) was identified on 11/14/25. The IJ template was provided to the facility on [DATE] at 7:12 PM. While the IJ was removed on 11/15/25, the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained. This failure placed other female residents at risk and or potential risk of abuse/neglect Findings Included: Record review of Resident #2's face sheet dated 11/15/25 reflected she was a [AGE] year-old female admitted into the facility 09/22/25 with a diagnosis of senile degeneration of brain (a general term for a decline in memory, thinking, and other cognitive abilities associated with aging). Record review of Resident #2's care plan dated 9/22/25 reflected ADL self-care performance deficit impaired mobility/cognition. Goal was to maintain current level of function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. Interventions were to converse with resident while providing care, explain all procedures before starting, promote dignity by ensuring privacy, staff will provide appropriate level of physical assistance with ADL's, encourage them to participate to the fullest extent possible. Record review of Resident #2's initial assessment MDS dated [DATE] reflected a BIMS score of 01 (Severe Cognitive Impairment).Record review of Resident #1's face sheet dated 11/15/25 reflected he was a [AGE] year-old male admitted into the facility 07/14/25 with a diagnoses of brain compression (a serious condition caused by increased pressure within the skull that pushes the brain against its rigid covering), and Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #1's care plan dated 9/3/25 reflected a focus of elopement risk and significantly intrudes on the privacy or activities, the goal was to maintain safety and would not leave the facility. Interventions/tasks were to distract resident from wandering by activities, food, conversation, television, document wandering behavior, identify pattern of wandering determine if aimless or escapist, is resident looking for something or did the wondering indicate he needed more exercise. Focus was a potential to demonstrate physical and verbal aggressive behaviors/manic episodes. Goal was to demonstrate effective coping skills and would not harm self or others. Interventions/tasks were to assess and anticipate resident's needs such as food, thirst, toileting needs, comfort and body position, pain. Communication provides physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, encourage seeking out of staff members when agitated. When he becomes agitated, guide away from source of distress, engages calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. Record review of Resident #1's quarterly MDS dated [DATE] reflected he had a BIMS score of 09 (Moderately Cognitive Impaired).Record review of progress notes of Resident #1 dated 11/4/25 at [1:59 PM] by LVN-B reflected, Kept going in other rooms while during shift, was found in multiple ladies' room and assisting residents to the restroom & was found after that in multiple male's room making beds. This nurse [LVN-B] discussed not going into rooms with the resident. Resident verbalized understanding. Notified NP of behaviors noted during this shift.Record review of progress note dated 11/05/25 at 3:32 AM for Resident #1 by LVN-C reflected, Res up and walking around hall and roaming in and out other patient's rooms. Res very aggressive and hard to redirect, tried to do virtual visit but iPad dead awaiting charging to call on call MD. [sic]Record review of progress note dated 11/05/25 at 4:23 AM for Resident #1 by LVN-C reflected, Res still agitated and aggressive. PRN orazepam was given but not effective. Res going in multiple women's rooms on unit. Hard to redirect. Res has been up all night walking and talking to self. [sic]Record review of progress note dated 11/05/25 at 4:50 AM for Resident #1 by LVN-C reflected, change in condition behavioral systems, nursing observations, evaluation, and recommendations are: Res has been up all night and going into female resident's rooms and when staff try to have him leave out room res becomes very aggressive in tone and hard to remove with verbal redirection. Res starts making demands like for food or water ect. Res was given PRN Ativan. Called spoke to on call NP. Gave order to give an additional Ativan of 0.5 mg and have NP and MD see patient once in facility. [sic]Record review of progress note dated 11/05/25 at 5:14 AM for Resident #1 by LVN-C reflected, PRN administration was: ineffective no change in behavior Record review of Behavioral Changes and Sleep

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours after the allegation was made, if the events that caused the allegation involve abuse to the administrator of the facility and to other officials including to the State Survey Agency in accordance with State law through established procedures for 2 of 8 residents (Resident #1 and Resident #2) reviewed for abuse and neglect.The facility did not make a report to local law enforcement or State Survey Agency (HHS) of an allegation on 11/05/25 when Resident #1 was found in the dining room massaging the breast of Resident #2 after he had taken off her adult brief. This failure could place residents at risk harm to include sexual abuse and could lead to diminished quality of life and psychosocial harm.Record review of Resident #2's face sheet dated 11/15/25 reflected she was a [AGE] year-old female admitted into the facility 09/22/25 with a diagnosis of senile degeneration of brain (a general term for a decline in memory, thinking, and other cognitive abilities associated with aging). Record review of Resident #2's care plan dated 9/22/25 reflected ADL self-care performance deficit impaired mobility/cognition. Goal was to maintain current level of function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. Interventions were to converse with resident while providing care, explain all procedures before starting, promote dignity by ensuring privacy, staff will provide appropriate level of physical assistance with ADL's, encourage them to participate to the fullest extent possible. Record review of Resident #2's initial assessment MDS dated [DATE] reflected a BIMS score of 01 (Severe Cognitive Impairment).Record review of Resident #1's face sheet dated 11/15/25 reflected he was a [AGE] year-old male admitted into the facility 07/14/25 with a diagnoses of brain compression (a serious condition caused by increased pressure within the skull that pushes the brain against its rigid covering), and Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #1's care plan dated 9/3/25 reflected a focus of elopement risk and significantly intrudes on the privacy or activities, the goal was to maintain safety and would not leave the facility. Interventions/tasks were to distract resident from wandering by activities, food, conversation, television, document wandering behavior, identify pattern of wandering determine if aimless or escapist, is resident looking for something or did the wondering indicate he needed more exercise. Focus was a potential to demonstrate physical and verbal aggressive behaviors/manic episodes. Goal was to demonstrate effective coping skills and would not harm self or others. Interventions/tasks were to assess and anticipate resident's needs such as food, thirst, toileting needs, comfort and body position, pain. Communication provides physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, encourage seeking out of staff members when agitated. When he becomes agitated, guide away from source of distress, engages calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. Record review of Resident #1's quarterly MDS dated [DATE] reflected he had a BIMS score of 09 (Moderately Cognitively Impaired).Record review on 11/13/25 of Resident #2 and Resident #1's progress notes did not reflect documentation of the sexual incident, no documentation of notification to doctor, and no documentation of notification to designated representative. On 11/13/25 the State Surveyor observed the video dated 11/5/25 , on the facility monitor, the video revealed the following:At 08:03 AM, Resident #1 left the dining room with a food tray and walked back into the dining room. At 08:29 AM Resident #1 came out of the dining room again and threw a bag away and went back into the dining room. At 08:30 AM CNA-A went into the dining room and came out of the room with Resident #2 and took her down the hall. Resident #1 followed CNA-A and Resident #2 out of the dining room and down the hallway, he was holding a green piece of material in his hand. A few minutes later at 08:51 AM Resident #2 was brought back to the hallway across from the nurses station. Resident #2 was sitting in the hall alone on a bench when Resident #1 went to the counter and stood there a few seconds and then walked over to Resident #2 turned around and kissed her on the top of her head.Record review of undated written statement of CNA-A reflected, This morning I witness [Resident #1] coming out of the dining room with a pull-up in his hand. I ask my co-worker where did he get it, he headed back to the dining room and shut the door that's when I went to check to see why he shut the door, as I enter the room both residents were standing by the table [Resident #1] in front of her massaging her chest with his hands holding (She had the top shirt on) her tank top. I told him to stop I patted the pt, realized her brief was

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for 2 of 18 residents (Resident #1, Resident #2) reviewed for abuse and neglect.The facility failed to thoroughly investigate inappropriate sexual behavior between Resident #1 and Resident #2. Resident #1 was observed in the dining room by CNA-A massaging the breast of Resident #2.An Immediate Jeopardy (IJ) was identified on 11/14/25. The IJ template was provided to the facility on [DATE] at 7:12 PM. While the IJ was removed on 11/15/25, the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. Findings included: Record review of Resident #2's face sheet dated 11/15/25 reflected she was a [AGE] year-old female admitted into the facility 09/22/25 with a diagnosis of senile degeneration of brain (a general term for a decline in memory, thinking, and other cognitive abilities associated with aging). Record review of Resident #2's care plan dated 9/22/25 reflected ADL self-care performance deficit impaired mobility/cognition. Goal was to maintain current level of function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. Interventions were to converse with resident while providing care, explain all procedures before starting, promote dignity by ensuring privacy, staff will provide appropriate level of physical assistance with ADL's, encourage them to participate to the fullest extent possible. Record review of Resident #2's initial assessment MDS dated [DATE] reflected a BIMS score of 01 (Severe Cognitively Impairment).Record review of Resident #1's face sheet dated 11/15/25 reflected he was a [AGE] year-old male admitted into the facility 07/14/25 with a diagnoses of brain compression (a serious condition caused by increased pressure within the skull that pushes the brain against its rigid covering), and Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #1's care plan dated 9/3/25 reflected a focus of elopement risk and significantly intrudes on the privacy or activities, the goal was to maintain safety and would not leave the facility. Interventions/tasks were to distract resident from wandering by activities, food, conversation, television, document wandering behavior, identify pattern of wandering determine if aimless or escapist, is resident looking for something or did the wondering indicate he needed more exercise. Focus was a potential to demonstrate physical and verbal aggressive behaviors/manic episodes. Goal was to demonstrate effective coping skills and would not harm self or others. Interventions/tasks were to assess and anticipate resident's needs such as food, thirst, toileting needs, comfort and body position, pain. Communication provides physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, encourage seeking out of staff members when agitated. When he becomes agitated, guide away from source of distress, engages calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. 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Resident #2 was sitting in the hall alone on a bench when Resident #1 went to the counter and stood there a few seconds and then walked over to Resident #2 turned around and kissed her on the top of her head.Record review of undated written statement of CNA-A reflected, This morning I witness [Resident #1] coming out of the dining room with a pull-up in his hand. I ask my co-worker where did he get it, he headed back to the dining room and shut the door that's when I went to check to see why he shut the door, as I enter the room both residents were standing by the table [Resident #1] in front of her massaging her chest with his hands holding (She had the top shirt on) her tank top. I told him to stop I patted the pt. realized her brief was off, grabbed her and started walking her out to notify my nurse and pt telling me he has her and I replied: I got her. [sic]Record review of the facility undated investigation reflected, We, [Administrator and DON, interviewed CNA-A 11/5/25 after