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	12/05/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (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 12/05/2025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 6 residents (Resident #1) reviewed for assessments: The facility failed to ensure Resident #1's quarterly MDS assessment, dated 09/23/25, included the behavior of wandering in Section E of the assessment. These failures could place residents at risk for inadequate care.Findings include:Record review of Resident #1's face sheet, dated 10/07/25, reflected an [AGE] year-old male, who admitted to the facility on [DATE]. Resident #1 had diagnoses which included Heart Failure, Schizoaffective Disorder (mental disorder with persistent hallucinations, delusions, disorganized thinking and speech, and bizarre or inappropriate behavior), Insomnia (difficulty falling asleep or staying asleep), Dysphagia (difficulty swallowing which can lead to choking), Repeated Falls, Type 2 Diabetes (body does not use insulin effectively or does not produce enough insulin), Essential Hypertension (High Blood Pressure), Muscle Weakness, and Cognitive Communication Deficit (inability to communicate effectively).There was no diagnosis of Dementia (decline in cognitive functions) on Resident #1's face sheet.Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 00, which meant he had severe cognitive impairment. Section E of the MDS assessment noted the resident had no wandering behaviors. The MDS did not note Dementia as a diagnosis for Resident #1.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia. Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia.In an interview on 10/08/25 at 12:45 PM, the DON stated Resident #1 did not have a diagnosis of Dementia. She stated staff might not been paying attention or accidentally selected Dementia as a diagnosis for Resident #1 on the Elopement Wandering Assessments. The DON reviewed all the assessments and stated she was not aware she also selected Dementia on one of Resident #1's assessments by accident. The DON stated whoever completed the assessment was responsible for ensuring the accuracy. The DON stated selecting Dementia as a diagnosis could affect the outcome of the assessment. She stated it could put the resident at a higher risk for elopement or wandering if selected incorrectly. She stated the wandering should be documented on all assessments on the resident's electronic record related to behavior. The DON stated the risk of noting Resident #1 had a diagnosis of Dementia or not noting the wandering behavior was the resident could be in places where he should not be and potentially be harmed.In an interview on 10/08/25 at 1:10 PM, the Administrator stated he had a lack of clinical background but would think the risk of inaccurate information on the electronic record could cause inaccurate results of assessments which could affect the resident. He stated the nursing staff were responsible for completing the assessments. Record review of the facility's policy titled, Resident Assessments, dated 11/2016 reflected the following: Policy It is the policy of this facility that residents will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified. An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history and preferences, using the RAI (Resident Assessment Instrument).

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #1) of 6 residents, reviewed for care plans. The facility failed to ensure a care plan was developed to address Resident #1's wandering behavior and note interventions prior to 09/30/25. This failure could place resideFindings Include:Record review of Resident #1's face sheet, dated 10/07/25, reflected an [AGE] year-old male, who admitted to the facility on [DATE]. Resident #1 had diagnoses included Heart Failure, Schizoaffective Disorder (mental disorder with persistent hallucinations, delusions, disorganized thinking and speech, and bizarre or inappropriate behavior), Insomnia (difficulty falling asleep or staying asleep), Dysphagia (difficulty swallowing which can lead to choking), Repeated Falls, Type 2 Diabetes (body does not use insulin effectively or does not produce enough insulin), Essential Hypertension (High Blood Pressure), Muscle Weakness, and Cognitive Communication Deficit (inability to communicate effectively).Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 00, which meant he had severe cognitive impairment. It also noted the resident had no wandering behaviors.Record review of Resident #1's Care Plan, dated 10/07/25, reflected wandering was not addressed on the care plan until 09/30/25, when the facility decided to place Resident #1 in memory care. Record review of Resident #1's quarterly elopement risk assessment dated [DATE], reflected Resident #1 had a history of wandering but did not exhibit wandering behavior at the time of the assessment.Record review of Resident #1's quarterly elopement risk assessment dated [DATE], reflected Resident #1 had a history of wandering but did not exhibit wandering behavior at the time of the assessment.Record review of Resident #1's quarterly elopement risk assessment dated [DATE], reflected Resident #1 had a history of wandering but did not exhibit wandering behavior at the time of the assessment.In an interview with the DON and the Administrator on 10/07/25 at 12:00 PM, the DON stated Resident #1 had wandered the facility since she became the DON at the facility about two years ago. The DON stated Resident #1 was already a resident at the facility when she started working there. The DON stated the resident started to wander more recently. The DON stated in the past he wandered up and down the hallway and would sit at the front near the dining hall. The DON stated now he started to wander into other areas, and that was what prompted the staff to add wandering to the care plan on 09/30/25. The DON stated she, the Administrator, and Medical Director decided it was best to address the wandering and to admit Resident #1 to memory care. The Administrator stated he noticed Resident #1 started to wander more than in the past.In an interview on 10/07/25 at 12:19 PM, Nurse Aide A stated Resident #1 had always wandered the hallways and started to wander more recently. She stated the resident was starting to wander into other resident rooms. She stated in the past he would wander up and down the hallways, to the dining hall, would wait at the door for smoke breaks, and would go down to the therapy room.In an interview on 10/07/25 at 12:47 PM, The Medical Director stated Resident #1 was a regular wanderer around the facility, but lately he started to wander into other areas like the administration offices, into resident rooms, and tried to go to the kitchen.In a follow up interview on 10/08/25 at 12:45 PM, the DON stated as long as she had worked at the facility, Resident #1 was a wanderer, but he mainly wandered in the same areas. She stated within the last 30 days Resident #1's wandering increased, so they decided to add wandering to the care plan and place him in memory care on 09/30/25. The DON stated wandering was never added to the care plan, because it was routine wandering, he would go to the same places, and he never tried to exit the facility. The DON stated the risk of wandering not addressed in the care plan prior to 09/30/25 was staff would not be fully aware of all his behaviors and/or symptoms and how to address each best.In a follow up interview on 10/08/25 at 1:10 PM, the Administrator stated staff might not have known Resident #1's full needs with wandering not addressed in the care plan. He stated all of a resident's behaviors should be addressed in the care plan.Record review of the facility's policy titled, Resident Assessments, dated 11/2016, reflected the following: 5.Assessment information will be used to develop, review, and revise the resident's comprehensive care plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 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, in accordance with professional standards and practices, medical records were maintained on each resident that that were complete and accurately documented for 1 of 6 resident records (Resident #1) reviewed for treatment documentation. The facility failed to document Resident #1's routine wandering since his admission on [DATE] and his increased wandering about 2-4 weeks before 09/30/25.The facility failed to ensure 8 of Resident #1's Elopement Wandering Assessments, did not note an incorrect diagnosis of Dementia.This failure could place residents at risk of medical records not being an accurate representation of medical condition or medical needs. Findings include:Record review of Resident #1's face sheet, dated 10/07/25, reflected an [AGE] year-old male, who admitted to the facility on [DATE]. Resident #1 had diagnoses which included Heart Failure, Schizoaffective Disorder (mental disorder with persistent hallucinations, delusions, disorganized thinking and speech, and bizarre or inappropriate behavior), Insomnia (difficulty falling asleep or staying asleep), Dysphagia (difficulty swallowing which can lead to choking), Repeated Falls, Type 2 Diabetes (body does not use insulin effectively or does not produce enough insulin), Essential Hypertension (High Blood Pressure), Muscle Weakness, and Cognitive Communication Deficit (inability to communicate effectively). Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 00, which meant he had severe cognitive impairment. It also noted the resident had no wandering behaviors.Record review of the Progress Notes, with a start date of 03/02/23, on Resident #1's Electronic Record, reflected no notations of Resident #1's behavior of wandering, increased wandering, or any incidents with wandering. Record review of Resident #1's quarterly elopement risk assessment dated [DATE], reflected Resident #1 had a history of wandering but did not exhibit wandering behavior at the time of the assessment. The assessment noted a low risk for elopement. Record review of Resident #1's quarterly elopement risk assessment dated [DATE], reflected Resident #1 had a history of wandering but did not exhibit wandering behavior at the time of the assessment. The assessment noted a low risk for elopement.Record review of Resident #1's quarterly elopement risk assessment dated [DATE], reflected Resident #1 had a history of wandering but did not exhibit wandering behavior at the time of the assessment. The assessment noted a low risk for elopement.Record review of Resident #1's quarterly elopement risk assessment dated [DATE], reflected Resident #1 had an increased risk of elopement and noted him as a high risk for elopement. Record review of the Incident Report Log, dated 10/07/25, did not reflect any wandering incidents. Record review of Resident #1's Care Plan, dated 10/07/25, reflected wandering was not addressed on the care plan until 09/30/25, when the facility decided to place Resident #1 in memory care.Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 00, which meant he had severe cognitive impairment. Section E of the MDS assessment noted the resident had no wandering behaviors. The MDS did not note Dementia as a diagnosis for Resident #1.Record review of Resident #1's quarterly Elopement Wandering assessment dated [DATE], reflected Resident #1 had a diagnosis of Dementia. 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In an interview on 10/08/25 at 12:45 PM, the DON stated Resident #1 had always wandered around but mostly wandered the hallways and near the dining area at the front. She stated it was about 2 weeks ago when the resident had a change in condition and wandered more around the building. The DON stated he started going into other residents' rooms and in other areas where he would not normally go. She stated she discussed it with the Administrator and the Medical Director. The DON stated she really had no reason as to why his wandering was not documented on his electronic record. The DON stated the risk of his wandering not ever documented on the progress notes