

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 03/24/2025
NAME OF PROVIDER OR SUPPLIER Park Village Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on observation, record review and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior environment for one residents' room (room [ROOM NUMBER] 301) of 6 residents' rooms reviewed for clean and sanitary environment.</p> <p>The shared bathroom in resident room [ROOM NUMBER] 301 had a water leak coming from underneath the toilet seat crossing in front of the sink and going to the shower drain.</p> <p>These failures could affect residents by placing them at risk of not having a clean, sanitary, and comfortable environment.</p> <p>Findings included:</p> <p>1. Observation of Resident #69, and Resident#32's shared bathroom on 03/18/2 at 10:41 AM showed a water leak coming from underneath the toilet seat crossing in front of the sink and going to the shower drain.</p> <p>Observation/Interview with Maintenance Director on 03/19/25 at 09:02 AM he looked at the bathroom floor in room [ROOM NUMBER] 301 and stated it may have a leak somewhere. He flushed the toilet and looked under the toilet tank and stated the leaking is from under the tank. He stated did not know about this leak in the Residents' Bathroom . He stated his staff do water flush monthly in all the residents' bathrooms and check the residents' rooms status at the same time He stated, he would get it fixed. He stated the risk to the resident, resident could slip and fall because of the water in the floor.</p> <p>Interview on 03/20/2025 at 09:45 AM with LVN C, she stated did not know about the water in the residents' bathroom. She stated any staff who noticed the water on the floor should put the wet floor signage in front of the bathroom and put an order in the system for the maintenance supervisor to fix it. She stated the risk to residents was they can fall.</p> <p>Interview on 03/22/25 at 4:53 PM the DON stated she expected CNAs to report it, log it in the maintenance department log system, called it in to them, and put yellow signage in front of the bathroom. She stated she expected the maintenance supervisor to fix the leak. She stated the risk to residents injury.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/22/25 at 5:16 the administrator stated, he expected the staff to report the leak in the residents' room toilet to maintenance supervisor, and for maintenance supervisor to fix it. He stated the risk to residents fall.</p> <p>Review of facility policy dated 06/2013 titled Policy and procedure for Falls, Standard. This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on interview and record review, the facility failed to protect the residents right to be free from physical abuse by Resident #60 for 1 resident (Resident #6) of 24 residents reviewed for abuse and neglect.</p> <p>On 01/25/25, Resident # 60 swung at Resident #6 and hit Resident # 6's right eye. Resident # 6 sustained bruising under the right eye.</p> <p>This failure placed the facility's residents at risk for abuse and neglect.</p> <p>Findings included:</p> <p>Record review of Resident #6's annual MDS, dated [DATE], reflected she was an [AGE] year-old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). Resident#6 has a BIMS score of 02/15 indicating severe cognitive impairment.</p> <p>Record review of the Resident#60 Quarterly MDS, dated [DATE], reflected she was [AGE] years old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). Resident#60 has a BIMS score of 05/15 indicating severe cognitive impairment.</p> <p>Interview on 03/18/25 at 1:35 PM with LVN C, revealed at first, she did not remember the incident, and after she looked at her notes, she stated yes that day (01/25/25) the residents (Resident#6, Resident#60) had an altercation here in front of the nursing station. She stated CNA A separated them. She stated, she assessed both residents and Resident #6 had a bruise under her right eye, and Resident #60 did not have any bruising . She stated she reported the incident to the MD, ADON, and DON . LVN C denied any Based on interview and record review, the facility failed to protect the residents right to be free from physical abuse by Resident #60 for 1 resident (Resident #6) of 24 residents reviewed for abuse and neglect.</p> <p>On 01/25/25, Resident # 60 swung at Resident #6 and hit Resident # 6's right eye.</p> <p>This failure placed the facility's residents at risk for abuse and neglect.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #6's annual MDS, dated [DATE], reflected she was an [AGE] year-old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). Resident#6 has a BIMS score of 02/15 indicating severe cognitive impairment.</p> <p>Record review of the Resident#60 Quarterly MDS, dated [DATE], reflected she was [AGE] years old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). Resident#60 has a BIMS score of 05/15 indicating severe cognitive impairment.</p> <p>Interview on 03/18/25 at 1:35 PM with LVN C, revealed at first, she did not remember the incident, and after she looked at her notes, she stated yes that day (01/25/25) the residents (Resident#6, Resident#60) had an altercation here in front of the nursing station. She stated CNA A separated them. She stated, she assessed both residents and Resident #6 had a bruise under her right eye, and Resident #60 did not have any bruising . She stated she reported the incident to the MD, ADON, and DON . LVN C denied any other altercation between the two residents.</p> <p>Interview on 03/18/25 at 1:38 PM with CNA A, she stated Resident #6 was sitting on her wheelchair in front of the nursing station, when Resident #60 who was standing next to her swung at her and hit her right eye. CNA A stated she separate the two residents immediately. CNA A denied any other altercation between the two residents.</p> <p>In interview on 03/18/25 at 1:40 PM, Resident #6 was unable to respond to interview questions.</p> <p>In interview on 03/18/25 at 1:42 PM, Resident #60 stated did not remember the incident, and denied ever hitting another resident.</p> <p>Interview with the DON and Administrator on 03/18/25 at 1:58 PM revealed, both checked the incident document and stated after they investigated the incident, they did not report it because there was no identifiable intent from one resident to injure the other resident. The DON stated both residents still socialized with each other, and when both residents were interviewed the next day of the incident none of them remembered the incident. The DON and Administrator both stated the risk to residents could be continuous of harm. The Administrator further stated that he was the abuse coordinator for the facility and according to the facility policy/Provider letter Abuse is a willful infliction of injury.</p> <p>Review of the facility's Abuse: Prevention of and Prohibition Against, dated 2017, reflected:</p> <p>Policy</p> <p>It is the policy of this facility that ear resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Abuse is a will infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm . Instances of abuse of all residents, irrespective of any mental or physical condition causing physical; harm .</p> <p>D Prevention .</p> <p>2) The Facility will act to protect and prevent abuse and neglect from occurring within the Facility by .</p> <p>Identifying, assessing and are planning for appropriate interventions and monitoring of resident with needs and behaviors which might lead to conflict . such as, Physically aggressive behavior, such as hitting .</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on interview and record review, the facility failed to immediately report an alleged act of abuse to the State Survey Agency, for 2 residents (Resident #6 and 60) of 24 residents reviewed for abuse and neglect.</p> <p>The facility failed to immediately report an allegation of physical abuse.</p> <p>This failure placed the facility's residents at risk for abuse and neglect.</p> <p>Findings included:</p> <p>Record review of Resident #6's annual MDS, dated [DATE], reflected she was an [AGE] year-old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). Resident#6 has a BIMS score of 02/15 indicating severe cognitive impairment.</p> <p>Record review of the Resident#60 Quarterly MDS, dated [DATE], reflected she was [AGE] years old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). Resident#60 has a BIMS score of 05/15 indicating severe cognitive impairment.</p> <p>Interview on 03/18/25 at 1:35 PM with LVN C, revealed at first, she did not remember the incident, and after she looked at her notes, she stated yes that day (01/25/25) the residents (Resident#6, Resident#60) had an altercation here in front of the nursing station. She stated CNA A separated them. She stated, she assessed both residents and Resident #6 had a bruise under her right eye, and Resident #60 did not have any bruising . She stated she reported the incident to the MD, ADON, and DON . LVN C denied any other altercation between the two residents.</p> <p>Interview on 03/18/25 at 1:38 PM with CNA A, she stated Resident #6 was sitting on her wheelchair in front of the nursing station, when Resident #60 who was standing next to her swung at her and hit her right eye. CNA A stated she separate the two residents immediately. CNA A denied any other altercation between the two residents.</p> <p>In interview on 03/18/25 at 1:40 PM, Resident #6 was unable to respond to interview questions.</p> <p>In interview on 03/18/25 at 1:42 PM, Resident #60 stated did not remember the incident, and denied ever hitting another resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON and Administrator on 03/18/25 at 1:58 PM revealed, both checked the incident document and stated after they investigated the incident, they did not report it because there was no identifiable intent from one resident to injure the other resident. The DON stated both residents still socialized with each other, and when both residents were interviewed the next day of the incident none of them remembered the incident. The DON and Administrator both stated the risk to residents could be continuous of harm. The Administrator further stated that he was the abuse coordinator for the facility and according to the facility policy/Provider letter Abuse is a willful infliction of injury.</p> <p>Review of the facility's Abuse: Prevention of and Prohibition Against, dated 2017, reflected:</p> <p>Investigations</p> <p>1. All identified events are reported to the Administrator immediately.</p> <p>H. Reporting/Response</p> <p>2. All allegations of abuse, neglect .will be reported outside the facility and to the appropriate state or federal agencies in the applicable timeframes, as per this policy and applicable regulations.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 3 (Resident #14, Resident #64, Resident #69) of 6 residents reviewed for ADLs.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> 1- Resident #14 had his fingernails trimmed on 03/18/25. 2- Resident #64 had her fingernails cleaned and trimmed on 03/19/25. 3- Resident #69 had her fingernails cleaned and trimmed on 03/19/25. <p>These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings include:</p> <p>1-Review of Resident#14's Quarterly MDS assessment dated [DATE] reflected Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die), muscle wasting, and cognitive communication deficit. Resident#14 had a BIMS score of 06/15 which indicated Resident#14's cognition was severely impaired. Further review revealed Resident#14 required extensive assistance of one-person physical assistance with dressing, and personal hygiene.</p> <p>Review of Resident #14's Comprehensive Care Plan revised 06/12/24 reflected the following: Focus: ADL self-Care Performance Deficit r/t limited mobility, weakness . Goal: will safely perform . grooming, toilet use and personal hygiene with modified independence through the review date. Intervention .Staff will provide the level of physical assistance as needed with ADLs due to self-ability may fluctuate .</p> <p>An observation and interview on 03/18/25 at 10:32 AM revealed Resident #14 was lying in her bed. The nails on both hands were approximately 0.4cm in length extending from the tip of his fingers, and dark brown substance underneath the nails. Resident #14 was unable to answer questions.</p> <p>Interview on 03/18/25 at 11:09 AM, CNA F looked at Resident #14 fingernails and stated they looked long and dirty and needed to be trimmed and cleaned. CNA F stated CNAs were responsible to clean and trim residents' nails when providing care to resident. CNA F stated only nurses cut residents' nails if they were diabetic. CNA F stated the risk would be potential for infection and skin break down.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2-Record review of Resident #64's quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (elevated blood pressure), and muscle weakness. Resident #64 has a BIMS score of 06/15 indicating sever cognitive impairment. Further review revealed Resident #64 was setup or clean up assistance.</p> <p>Record review of Resident #64's care plan, dated 12/25/24, reflected she Focus. ADL Self Care Performance Deficit r/t CORDINATION DEFEICIT Goal. Will safely perform .Personal Hygiene through the review date. Interventions/Tasks. Praise all efforts at self-care.</p> <p>An observation on 03/19/25 at 10:16 AM revealed Resident #64 was sitting in the common area with other residents. The nails on both hands were approximately 0.75 centimeter in length extending from the tip of her fingers and had black area underneath the nails. Resident #64 was unable to participate in interview, and just kept looking at her fingernails.</p> <p>Interview on 03/19/25 at 10:18 AM CNA A looked at Resident#64 fingernail and stated they were long and some of them were dirty underneath. CNA A stated Resident #64 fingernails needed to be cleaned and trimmed. CNA A stated that fingernail clipping should be done weekly but also as needed and CNAs provided nail care unless the resident had diagnosis of diabetes (elevated blood glucose). She further stated the risk to the residents they could scratch them self, and development of infection.</p> <p>3- Record review of Resident #69's quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension, and anemia. Resident #69 has a BIMS score of 09/15 indicating moderate cognitive impairment. Further review revealed Resident #69 was substantial/maximal assistance with personal hygiene.</p> <p>Record review of Resident #69's care plan, dated 03/20/25, reflected she Focus. ADL self-Care Performance Deficit r/t COGNITIVE DEFICIT AND PHYSICAL DEPENDENCE W/ADL'S. Goal. Will maintain current level of function .Personal hygiene through the review date. Interventions/Tasks . Praise all efforts at self-care.</p> <p>An observation on 03/19/25 at 10:20 AM revealed Resident #69 was sitting in the common area with other residents. The nails on both hands were approximately 0.75 centimeter in length extending from the tip of her fingers and had black area underneath the nails. Resident #69 was unable to participate in interview, and just kept looking at her fingernails.</p> <p>Interview on 03/19/25 at 10:22 AM CNA A looked at Resident #69 fingernail and stated they were long and some of them were dirty underneath. CNA A stated Resident#69 fingernails needed to be cleaned and trimmed. CNA A stated that fingernail clipping should be done weekly but also as needed and CNAs provided nail care unless the resident had diagnosis of diabetes (elevated blood glucose). She further stated the risk to the residents they could scratch them self, and development of infection.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/20/25 at 09:45 AM with LVN C, she stated both CNAs and charge nurses in the Halls were responsible for residents' nail care. She stated if a resident had diabetes, only nurses were allowed to trim resident's nails. She stated the risk for not performing nailcare was increased risk of infection and skin break down.</p> <p>Interview on 03/22/25 at 4:54 PM with the DON, she stated her expectation was that nail care should be provided every day as needed. She stated that both CNAs and charge nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had diagnosis of diabetes. The DON stated residents who had dirty fingernails could be an infection control issue, and skin injury.</p> <p>Record review of the facility's policy titled Care of Nails, review date January 2022, reflected .Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis . Nail care will be provided between scheduled occasions as the need arises .</p> <p>47690</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing and administering, of medications for 2 (Nursing Medication cart hall 100 North and nursing medication cart 300 hall) of 3 medication carts reviewed for pharmacy services.</p> <p>The facility failed to ensure prompt identification of potential diversion of controlled medications when CMA B did not report a damaged blister pack of Clobazam 20 mg (controlled medication) and LVN D C did not report a damaged blister pack of Tylenol with Codeine#4 oral tablet 300-60 mg (controlled medication).</p> <p>This failure could place residents at risk of not having their medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication.</p> <p>Findings included:</p> <p>Record review of Resident #31's Quarterly MDS assessment, dated 01/12/25, reflected he was a [AGE] year-old male with admitted [DATE]. Resident #31's BIMS score was 12/15 which indicated moderate cognition. His diagnoses included diabetes mellitus (elevated blood sugar), dementia (diseases that affect memory, thinking, and the ability to perform daily activities), Alzheimer disease (is a brain disorder that causes memory loss, thinking problems, behavior changes, and brain cell death), hypertension (elevated blood pressure), and aphasia (Aphasia a language disorder that affects a person's ability to communicate).</p> <p>Record review of Resident #31's Physician order summary report dated March 2025, reflected . Clobazam 20 mg tablet Give 1 tablet by mouth two times a day . with a start date 03/06/25.</p> <p>An observation on 03/19/25 at 12:15 PM revealed the blister pack for Resident #31 Clobazam 20 mg (controlled medication) had 1 blister pack pill area seal broken and the pill still in the blister.</p> <p>Review of the controlled medication count sheet for Resident #31 Clobazam 20 mg reflected that the count was accurate when compared to the medications in the drawer.</p> <p>In an interview on 03/19/25 at 12:15 PM CMA B stated she was unaware when the blister pack seal became broken. She stated that the seals are easily torn when they are handled every shift to be counted. She stated the medication was supposed to be discarded if opened to prevent potential diversion of controlled medications.</p> <p>Record review of Resident #53's Quarterly MDS assessment, dated 02/23/25, reflected she was a [AGE] year-old female initially admitted to facility on 03/28/23, and readmitted on [DATE]. Resident #53's BIMS score of 8/15 which indicated moderate cognition. Her diagnoses included dementia (diseases that affect memory, thinking, and the ability to perform daily activities), and arthritis (a broad term for conditions affecting joints, tissues around joints, and other connective tissues, causing pain, stiffness, and reduced movement).</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident#53's Physician order summary report dated March 2025 reflected . Tylenol with Codeine #4 oral tablet 300-60 mg Give 1 Tablet by mouth every 8 hours as needed for pain . with a start date 05/07/24.</p> <p>An observation on 03/19/25 1:50 PM revealed the blister pack for Resident #53 blister pack of Tylenol with Codeine#4 oral tablet 300-60 mg had 1 blister pack pill area seal broken and the pill still in the blister.</p> <p>Review of the controlled medication count sheet for Resident #53 Tylenol with Codeine#4 oral tablet 300-60 mg reflected that the count was accurate when compared to the medications in the drawer.</p> <p>In an interview on 03/19/25 1:55 PM LVN D stated she was unaware when the blister pack seal became broken. She stated she didn't see it this morning when she counted with the night shift nurse. She stated the medication was supposed to be discarded if opened to prevent medication error that can harm the resident.</p> <p>In an interview on 03/19/25 at 2:25 PM, the DON revealed she expected if a blister pack medication seal is broken; the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk to residents would be giving the wrong and ineffective medication. DON stated charge nurses were responsible to check, every day, the carts for medications with broken seals during the count with the relieving nurses.</p> <p>Review of the facility's Storage of Medications policy, Revised April 2007, indicated . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427</p> <p>Based on observation, interview and record review the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for 1 of 8 residents (Residents #36) reviewed for dental services.</p> <p>The facility failed to provide timely dental services for Resident #36 when he started having tooth pain on 02/11/25.</p> <p>This failure could place residents at risk of oral complications, dental pain, and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #36's Quarterly MDS dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE]with the diagnoses of stroke, cognitive communication deficit, and unspecified pain. His BIMS score was a 13 (intact cognition).</p> <p>Record review of Resident #36's care plan revealed a focus area communication problem due to expressive aphasia and slurring. Interventions included encouraging resident to continue to state his thoughts if he was having difficulty, assist with finding words as needed/appropriate, and monitor/document for physical/nonverbal indicators of discomfort or distress and follow up as needed .</p> <p>In an interview on 03/18/25 at 12:58 PM with Resident #36 revealed he stated he had tooth pain for about a month that came and went and pointed to his bottom right jaw. He stated he had received pain medication for the tooth pain. He stated he would like to see the dentist and was not sure if he had an appointment.</p> <p>Record review of Resident #36's physician orders reflected an order with the start date of 11/22/24 for monitoring of pain using the pain scale from 0 (no pain) to 10 (severe pain) every shift.</p> <p>Record review of Resident #36's physician orders reflected an order with the start date of 11/22/24 for Acetaminophen tablet, 325 mg, give 2 tablets by mouth every 4 hours as needed for mild pain/headache.</p> <p>Record review of Resident #36's physician orders reflected an order with the start date of 2/11/25 for Tramadol 50 mg- give one tablet by mouth every 6 hours as needed for Pain.</p> <p>Record review of Resident #36's e-MAR for February 2025 reflected he was administered Tramadol 50mg on 02/20/25 at 4:31 PM, 02/21/25 at 2:55 PM and 10:15 PM, and 02/22/25 at 5:45 PM, and on 02/27/25 at 4:45 PM.</p> <p>Record review of Resident #36's e-MAR for 03/01/25-03/22/25 reflected he was administered Tramadol 50 mg on 03/18/25 and it was effective. Resident #36 had no pain except for on 03/18/25 for the month of March.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #36's e-MAR progress note, written by LVN I and dated 02/11/25 at 12:10 PM, reflected Acetaminophen Tablet 325 mg was administered .resident having a toothache pain 6/10 on scale . and it was effective.</p> <p>Record review of Resident #36's e-MAR progress note, written by LVN I and dated 02/11/25 at 5:45 PM, reflected the nurse practitioner ordered a dental referral and the social worker was made aware and the resident had a new order for the pain medication Tramadol 50mg every 6 hours for pain as needed.</p> <p>Record review of Resident #36's e-MAR progress note, written by LVN I and dated 02/18/25 at 9:34 PM, reflected Acetaminophen Tablet 325 mg was administered .toothache to lower right jaw, dental referral in place and was effective.</p> <p>Record review of Resident #36's e-MAR progress note, written by RN AD and dated 02/20/25 at 4:31 PM, reflected Tramadol 50 mg was administered to the resident for complaints of tooth pain and was effective upon follow up.</p> <p>Record review of Resident #36's e-MAR progress note, written by LVN I and dated 02/21/25 at 2:55 PM, reflected Tramadol 50 mg was administered to the resident due to toothache to right lower side of jaw rated 5/10 on pain scale and was effective upon follow up.</p> <p>Record review of Resident #36's e-MAR progress note, written by LVN Q and dated 02/22/25 at 10:15 PM, reflected Tramadol 50 mg was administered to the resident due for pain and was effective upon follow up.</p> <p>Record review of Resident #36's e-MAR progress note, written by LVN I and dated 02/26/25 at 9:59 AM, reflected resident had a toothache to the lower right jaw.</p> <p>Record review of Resident #36's e-MAR progress note, written by RN AD and dated 02/27/25 at 4:45 PM, reflected Tramadol 50 mg was administered to the resident for toothache and was effective upon follow up.</p> <p>Record review of Resident 36's e-MAR progress note, written by RN AD and dated 03/18/25 at 4:45 PM, reflected Resident #36 was administered Tramadol 50 mg for pain and it was effective.</p> <p>Record review of Resident #36's social services progress note, written by the Social Worker, dated 03/19/25 at 4:01 PM, reflected the resident stated he was not having tooth pain at that time and a dental visit was scheduled for Friday, 03/21/25.</p> <p>Record review of Resident #36's nurse's progress note, written by LVN I and dated 03/21/25 at 2:20 PM, reflected he had complaints of tooth pain and pain medication was administered with effective results and he was seen by dental services.</p> <p>Record review of dental referral, dated faxed on 03/14/25, by the Social Worker, reflected Resident #36 had signed the authorization on 03/13/25.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of email, subject line: [Resident #36] dental dated 03/19/25 from the Social Worker to dental services revealed the fax was missed by dental services. Further review revealed Resident #36 was seen by dental services on 3/21/25. Resident #36 was a new patient and had a chart review, x-rays, and photos by the dental hygienist and would see the physician in a week.</p> <p>In an interview on 03/19/25 at 3:15 PM with RN AD revealed Resident #36 occasionally had tooth pain and leg pain. She stated the nurse practitioner had been notified and a new order was given for Tramadol 50 mg as needed for the pain. She stated the social worker was working on a dental referral for the resident.</p> <p>In an interview on 03/19/25 at 3:24 PM with LVN I revealed she had notified the nurse practitioner that Resident #36 had tooth pain and a new order was given of Tramadol 50 mg. She stated she knew the resident had a dental referral because the social worker handled the referrals and she talked to her on the phone about the resident's tooth pain.</p> <p>In an interview on 03/22/25 at 1:20 PM with the Social Worker revealed she was responsible for dental referrals and if a resident had dental concerns such as pain the nurse would typically tell her. She stated she did not recall anyone informing her of Resident #36's the tooth pain in February 2025 and would have immediately sent a dental referral if she had known. She stated nurses, residents, or their representative usually informed her of any referrals needed and she would coordinate the consents and paperwork. She stated she talked to Resident #36 on 03/19/25 and asked if he had pain with his mouth, which he denied, and she asked him if it was okay to have dental come see him. She stated Resident #36 agreed, signed the consents and dental services saw him on 03/21/25. She stated this was not a timely referral, it typically took 2-3 days for the non-emergency referrals. She stated it was important to ensure residents received timely referrals to ensure they received their needed services.</p> <p>In an interview on 3/23/25 8:41 AM with Administrator revealed dental referrals are the social worker's responsibility. He stated if a resident had dental pain the nurse notified the social worker and the social worker coordinated the referral. He stated depending on situation a resident would be seen by dental services within days and not longer than a week. He stated Resident #36 referral should have been completed sooner. He stated it was important for residents to have timely referrals to ensure pain is managed and to receive needed dental services.</p> <p>Record review of the facility's referral policy titled Outside Referrals, revised July 2013, reflected: .the facility will make necessary arrangements for services to be furnished to the resident by a person or agency outside the facility .</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview, and record review, the facility failed to maintain an Infection Control Program designed to help prevent the transmission of disease and infection; maintain a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, and visitors; follow accepted national standards; follow a system of surveillance designed to identify possible communicable diseases or infections before they could spread to other persons in the facility; follow standard and transmission-based precautions to prevent spread of infections for twenty eight residents (Residents #1, #6, #7, #8, #10, #11, #13, #15, #19, #20, #27, #28, #38, #41, #44, #48, #49, #52, #54, #55, #57, #60, #63, #64, #66, #69, #71, and #73) of seventy three residents reviewed for infection and two (Resident #1 and #59) of three residents observed for incontinence care and one (Resident #277) of one resident observed for wound care.</p> <p>The facility failed to identify the outbreak, isolate the residents and perform proper hand hygiene as per CDC guidelines.</p> <p>The facility failed to implement and maintain contact precautions. Residents with gastrointestinal symptoms were participating in group meetings and eating food in the dining room with residents that were not sick. Residents with gastrointestinal illness were in their rooms with residents that were not displaying symptoms.</p> <p>The facility failed to perform proper cleaning and decontamination of infected rooms.</p> <p>The facility failed to report the outbreak to the local authority.</p> <p>The facility failed to have a system in place to evaluate and screen employees for nausea, vomiting and diarrhea symptoms.</p> <p>As a result, the facility experienced an outbreak of suspected norovirus beginning on 03/17/25.</p> <p>2. The facility failed to ensure CNA E changed her gloves and performed hand hygiene while providing incontinence care to Resident #1 on 03/18/25.</p> <p>3. CNA A failed to wear appropriate PPE when providing incontinent care for Resident #59 who supposed to be on EBP.</p> <p>These failures place the residents at risk of exposure to possible infectious agents.</p> <p>4. The facility failed to ensure ADON J donned the appropriate PPE during wound care for Resident #277, who was on enhanced barriers precautions, on 03/19/25.</p> <p>5. The facility failed to implement and train staff on transmission-based precautions for symptomatic residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>These failures placed the residents residing in the facility at risk for the development of GI outbreak and related complications including dehydration and cross-contamination of pathogens and illness.</p> <p>An Immediate Jeopardy was identified on 03/20/25. The IJ template was provided to the facility on [DATE] at 1:40 PM. While the Immediate Jeopardy was removed on 03/24/25, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not Immediate Jeopardy, due to facility continuation of in-servicing and monitoring the plan of removal.</p> <p>Findings Included:</p> <p>1. Record review of the facility's 24-hour report for 03/17/25 to 03/18/25 reflected Residents #15, #20, #27, #54, #55, #60, #66, and #71 had nausea and vomiting; Resident #19 had vomited twice; Resident #44 had vomited on 03/17/25 and 03/18/2025; Resident #28, #57, and had vomited once; Resident #10 and #11 had diarrhea once and was given Imodium for next diarrhea .; Resident #277 had a new order by physician to test for c.diff [Clostridioides difficile](a bacterial infection of the colon).</p> <p>Record review of the facility's infection control mapping dated 3/18/25 reflected 21 residents had signs and symptoms of nausea/vomiting or diarrhea.</p> <p>Record review of the facility's 24-hour report dated 03/18/25 to 03/19/25 reflected Resident #7, #15, #27, #32, #50, #54, #56, #64, #60, #71, had nausea, vomiting, and diarrhea.</p> <p>Record review of the facility's 24-hour report dated 03/19/25 to 03/20/25 reflected Resident #8 had an episode of diarrhea; Resident #4 laxative was held due to resident having diarrhea, Resident #51 had vomiting. Resident #41 had a change of condition with diarrhea and new order for Imodium every 6 hours for diarrhea as needed. Resident #57 had administration of laxative held due to diarrhea. Resident #48 had nausea, vomiting, and diarrhea.</p> <p>Record review of the facility's 24-hour report dated 03/20/25 to 03/21/25 reflected Resident #1, #8, #27, #32, #41, #52, #54, #64, were on contact precautions for diarrhea. Resident #277 tested positive for c.diff [Clostridioides difficile](a bacterial infection of the colon), isolation precautions were in place and she had no diarrhea or gastrointestinal complaints. Resident #48's administration of laxative was held due to loose stool earlier and Zofran was administered.</p> <p>In a confidential group interview on 03/19/25 residents stated that they had experienced loose stools, nausea, and vomiting for the past few days. They stated that they had not been on any isolation precautions, had been given Imodium and Zofran and it helped the symptoms.</p> <p>2-Record review of Resident #7's Quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of cognitive communication deficit, seizure disorder, and a BIMS score of 8 (moderately impaired cognition). Resident #7 was occasionally incontinent of urine and always continent of bowl.</p> <p>Record review of Resident #7's care plan, dated initiated 03/20/25 revealed a focus area of: Risk for infection r/t Active communicable pathogen (GI SYMPTOMS TO INCLUDE: NAUSEA/VOMITING/DIARRHEA) . interventions included educating resident on handwashing, monitoring for signs and symptoms of active infection, and notify physician.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #7's physician orders revealed an order for enhanced barrier precautions with a start date of 02/28/2025 and a wound to her right shin with a start date of 02/13/25.</p> <p>Record review of Resident #7's POC Response History (CNAs documentation in the resident's chart) revealed Resident #7 had episodes of diarrhea on 03/16/2025 at 1:06 PM, 03/17/2025 at 6:44 PM, 03/19/2025 at 3:56 AM, 12:35 PM, and 9:33 PM and on 03/20/2025 at 2:35 PM.</p> <p>Record review of Resident #7's progress note dated 03/15/2025 at 3:52 AM reflected Resident complaining of nausea at this time. Per standing orders Phenergan 12.5 mg given by mouth. NP notified of nausea . Note dated 03/19/2025 at 2:09 AM reflected Resident has been complaining of loose stool this shift.</p> <p>In an attempt to interview Resident #7 on 03/18/2025 at 10:53 AM revealed she was non-interviewable.</p> <p>Observation of Resident #7 on 03/19/2025 at 9:15 AM revealed she was laying in bed asleep and had a brown stain on the seat of her pant. Further observation revealed Occupational Therapist (OT) AE entered Resident #7's room and asked if she was sick and if she wanted to get up for therapy. Resident #7 replied that she was not sick but she did not have breakfast because her stomach hurt and she wanted to go to therapy.</p> <p>In an interview on 03/19/25 at 10 AM with CNA G revealed she stated Resident #7 did not have any episodes of loose stools/diarrhea or vomiting and was able to use restroom herself. She stated nurses were notified for any change of condition.</p> <p>In an interview on 03/19/25 at 11 AM with RN AD revealed she stated Resident #7 did not have any nausea/vomiting/diarrhea and was on enhance barrier precautions due to a wound on her shin.</p> <p>2-Record review of Resident #48's Quarterly MDS assessment dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of stroke and cognitive communication deficit and BIMS score of 12 (moderately impaired cognition). Resident #48 was frequently incontinent of urine and always continent of bowl.</p> <p>Record review of Resident #48's physician orders revealed an order for Zofran dated 07/15/23: Zofran oral tablet 4 mg give by mouth every 4 hours as needed for nausea, and vomiting.</p> <p>Record review of Resident #48's POC Response History (CNAs documentation in the resident's chart) revealed Resident #48 had episodes of diarrhea on 03/19/2025 at 9:37 PM and 03/21/2025 at 1:45 PM and 8:36 PM.</p> <p>Record review of Resident #48's e-MAR dated 03/18/25 through 03/24/25 reflected, Resident#48 was administered Zofran on 3/19/2025 and 03/20/2025.</p> <p>Record review of Resident #48's progress note dated 03/19/2025 at 6:30 PM reflected Resident was given PRN Zofran and standing order Imodium for loose stoolx3 today .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #48's progress note dated 03/20/2025 at 7:18 PM reflected he was administered Zofran for mild nausea and at 7:28 PM resident's Colace for constipation was held due to loose stool earlier.</p> <p>3-Record review of Resident #13's Quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included dementia, cognitive communication deficit. Resident #13's BIMS score of 2 indicated her cognition was severely impaired. Resident #13 was frequently incontinent of urine and bowel.</p> <p>Record review of Resident #13's care plan dated 11/18/2024 reflected Resident #13 was at risk for impaired cognitive function/dementia or impaired thought process.</p> <p>Record review of Resident #13's progress note dated 03/21/2025 09:34 reflected Resident was having loose stools.</p> <p>Record review of Resident #13's POC Response History (CNAs documentation in the resident's chart) revealed Resident #13 had episodes of diarrhea on 03/18/2025 at 09:18 PM, 03/19/2025 at 02:27 AM, 03/19/2025 at 10:11 AM, 03/20/2025 at 03:47 AM.</p> <p>Record review of Resident #13's physician orders reflected resident #13 had a standing order on 03/18/2025 for Zofran Oral Tablet 4 MG (Ondansetron HCl) Give 4mg by mouth, administered every 4 hours as needed for Nausea and Vomiting, Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 2 mg by mouth every 6 hours as needed for Diarrhea.</p> <p>4-Record review of Resident #49's Quarterly MDS assessment dated [DATE] reflected she was an [AGE] year-old female with an initial admitted [DATE] with diagnoses included Alzheimer's disease, cognitive communication deficit. Resident #49's BIMS score of 4 indicated her cognition was severely impaired. Resident #49 was occasionally incontinent of urine.</p> <p>Record review of Resident #49's care plan dated 06/09/2022 reflected she was at risk for impaired cognitive function.</p> <p>Record review of Resident #49's progress note dated 03/21/2025 09:02 AM reflected resident is experiencing loose stools during patient care.</p> <p>Record review of Resident #49's POC Response History (CNAs documentation in the resident's chart) revealed Resident #49 had episodes of loose stool/diarrhea on 03/18/2025 at 08:56 PM, 03/19/2025 at 07:27 PM, 03/20/2025 at 10:22 AM and 09:59 PM.</p> <p>Record review of Resident #49's physician orders report reflected Resident #49 had a standing order on 03/18/2025 for Zofran Oral Tablet 4 MG (Ondansetron HCl) Give 4mg by mouth, administered every 4 hours as needed for Nausea and Vomiting, Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 2 mg by mouth every 6 hours as needed for Diarrhea.</p> <p>5-Record review of Resident #54's Quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female with an admitted [DATE] with diagnoses included dementia, cognitive communication deficit. Resident #54 was always incontinent of bowel and urine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #54's care plan dated 03/07/2023 reflected she had ADL self-care performance deficit, cognitive deficit and physical dependence required.</p> <p>Record review of Resident #54's progress note dated 03/18/2025 04:49 AM reflected resident had nausea and vomiting.</p> <p>Record review of Resident #54' POC Response History (CNAs documentation in the resident's chart) revealed Resident #54 had episodes of loose stool/diarrhea on 03/14/2025 at 12:22 AM and 07:33 PM, 03/17/2025 at 01:02 PM, 03/18/2025 at 02:15 AM, 01:59 PM and 08:17 PM.</p> <p>Record review of Resident #54's order summary reflected resident #54 had an as needed standing order on 03/18/2025 for Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 2 mg by mouth every 6 hours as needed for Diarrhea, Zofran Oral Tablet 4 MG (Ondansetron HCl) Give 4 mg by mouth every 4 hours as needed for Nausea and Vomiting.</p> <p>6-Record review of Resident #73's Quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female with an admitted [DATE] with diagnoses included dementia, cognitive communication deficit. Resident #73's BIMS score of 3 indicated her cognition was severely impaired. Resident #73 was occasionally incontinent of urine.</p> <p>Record review of Resident #73's care plan dated 02/21/2025 reflected resident had bowel/bladder incontinence related to Dementia.</p> <p>Record review of Resident #73's progress note dated 03/18/2025 04:49 AM reflected resident #73 had nausea and vomiting.</p> <p>Record review of Resident #73' POC Response History (CNAs documentation in the resident's chart) revealed Resident #54 had episodes of loose stool/diarrhea on 03/14/2025 at 12:22 AM and 07:33 PM, 03/17/2025 at 01:02 PM, 03/18/2025 at 02:15 AM, 01:59 PM and 08:17 PM, 03/19/2025 at 01:46 AM and 07:03 PM.</p> <p>Record review of Resident #73's physician orders reflected Resident #73 had standing order on 03/18/2025 for Zofran Oral Tablet 4 MG (Ondansetron HCl) Give 4 mg by mouth every 4 hours as needed for Nausea and Vomiting, Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 2 mg by mouth every 6 hours as needed for Diarrhea.</p> <p>7-Record review of Resident #69's quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension, and anemia. Resident#69 has a BIMS score of 09/15 indicating moderate cognitive impairment.</p> <p>Record review of Resident #69's care plan, dated 03/20/25, reflected she Focus. Risk for infection r/t Active communicable pathogen (GI SYMPTOMS TO INCLUDE: NAUSEA/VOMITING/DIARRHEA). Goal. Will be free of infection by review date. Will mitigate risk of transmission of a pathogen. Interventions/Tasks. Educate resident/family/caregivers regarding the importance of handwashing. Use soap and water and dry hands using disposable towels. Monitor for sign and symptoms of active infection and notify physician.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #69's physician orders reflected an order dated 03/20/25: Monitor each shift for nausea, vomiting, diarrhea. Notify MD for any of the symptoms.</p> <p>Record review of Resident #69's physician orders reflected an order dated 03/18/25: Zofran oral tablet 4 mg give by mouth every 4 hours as needed for nausea, and vomiting.</p> <p>Record review of Resident #69's physician orders reflected an order dated 03/18/25: Imodium A-D oral tablet 2 mg give by mouth every 6 hours as needed for diarrhea.</p> <p>e-MAR review for Resident#69 dated 03/18/25 through 03/24/25 reflected, Resident#69 was not administered Zofran and Imodium tablets.</p> <p>Record review of Resident #69's POC Response History (CNAs documentation in the resident's chart) dated 03/17/25 through 03/24/25 reflected Resident #69 had two loose stool/diarrhea on 03/18/25, and one loose stool/diarrhea on 03/19/25.</p> <p>8-Record review of Resident #6's annually MDS, dated [DATE], reflected she was an [AGE] year-old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension, and diabetes mellitus. Resident#6 has a BIMS score of 02/15 indicating sever cognitive impairment.</p> <p>Record review of Resident #6's care plan, dated 02/02/25, reflected she Focus. Has bowel/bladder incontinent r/t Dementia AND Physical ASSIST WITH ADL's. Goal. Will be free from skin breakdown due to incontinence and brief use through the review date. Interventions/Tasks. Incontinent: check as required for incontinence. Wash, rinse and dry perineum</p> <p>Record review of Resident #6's physician orders reflected an order dated 03/20/25: Monitor each shift for nausea, vomiting, diarrhea. Notify MD for any of the symptoms.</p> <p>Record review of Resident #6's physician orders reflected an order dated 03/18/25: Zofran oral tablet 4 mg give by mouth every 4 hours as needed for nausea, and vomiting.</p> <p>Record review of Resident #6's physician orders reflected an order dated 03/18/25: Imodium A-D oral tablet 2 mg give by mouth every 6 hours as needed for diarrhea.</p> <p>e-MAR review for Resident #6 dated 03/18/25 through 03/24/25 reflected, Resident#6 was not administered Zofran and Imodium tablets.</p> <p>Record review of Resident #6's Tasks titled Bowel movement/Bowel continence dated 03/17/25 through 03/24/25 reflected Resident#6 had one loose bowel movement on 03/18/25.</p> <p>9-Record review of Resident #27's quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension, anemia, and diabetes, mellitus. Resident#27 has a BIMS score of 02/15 indicating sever cognitive impairment.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #27's care plan, dated 02/02/25, reflected she Focus. Has an alteration in gastro-intestinal status r/t diarrhea, nausea, vomiting. Goal. Will remain free from discomfort, complications or s/sx related to gastro-intestinal alterations through review date. Will mitigate risk of transmission of a pathogen. Interventions/Tasks. Contact isolation precautions.</p> <p>Record review of Resident #27's physician orders reflected an order dated 03/20/25: Monitor each shift for nausea, vomiting, diarrhea. Notify MD for any of the symptoms.</p> <p>Record review of Resident #27's physician orders reflected an order dated 03/18/25: Zofran oral tablet 4 mg give by mouth every 4 hours as needed for nausea, and vomiting.</p> <p>Record review of Resident #27's physician orders reflected an order dated 03/18/25: Imodium A-D oral tablet 2 mg give by mouth every 6 hours as needed for diarrhea.</p> <p>e-MAR review for Resident #27 dated 03/18/25 through 03/24/25 reflected, Resident#27 was not administered Zofran and Imodium tablets.</p> <p>Record review of Resident #27's Tasks titled Bowel movement/Bowel continence dated 03/17/25 through 03/24/25 reflected Resident#27 had one loose bowel movement on 03/20/25.</p> <p>Interview on 03/20/25 at 09:40 AM, CNA A denied residents (Resident#6, Resident #59, Resident#27, Resident#69) had diarrhea in the last four days (03/17/25, 3/18/25, 3/19/25, and 3/20/25). She stated she was notified about the residents' symptoms during the shift change and getting report from the outgoing CNAs. CNA A stated do not have any resident with diarrhea in the unit now.</p> <p>Interview on 03/20/25 at 09:45 AM, LVN C denied residents (Resident#6, Resident #59, Resident#27, Resident#69) had diarrhea in the last four days (03/17/25, 3/18/25, 3/19/25, and 3/20/25). She stated there was no residents with diarrhea in the unit in the last four days. She stated residents (Resident#6, Resident #59, Resident#27, Resident#69) complained of nausea, and vomiting. She stated report the signs and symptoms to DON, MD, and family.</p> <p>In an interview on 03/20/25 at 10:58 AM with CNA N revealed she was out sick, and she denied having any gastrointestinal symptoms. She stated she had.</p> <p>10-Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected she was a 94 -year-old female admitted to the facility on [DATE] with diagnoses included dementia and cognitive communication deficit. Resident #1's BIMS score of 9, which indicated Resident #1' cognition was moderately impaired, Resident #1 was incontinent of bowel and bladder.</p> <p>Record review of Resident #1's Nurse note dated 03/18/25 at 7:02 AM reflected, Resident had episode of diarrhea. Medical doctor gave new order to initiate as needed standing order for Imodium 2 mg by mouth administered x 1 for diarrhea. Will continue to monitor.</p> <p>Record review of Resident #1' POC Response History (CNAs documentation in the resident's chart) revealed Resident #1 had one episode of loose stool/diarrhea on 3/18/25 at 7:07 AM and another episode on 3/19/25 at 4:21 AM.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 03/20/19 at 8:40 AM, with CNA E revealed that Resident #1 had diarrhea yesterday, CNA E said she told her charge nurse. She was unaware of Resident #1 having any more symptoms on her shift.</p> <p>Interview on 03/20/25 at 08:59 AM, with LVN I revealed that CNA E, on morning shift on 03/18/25 reported to her Resident #1 had diarrhea. She stated Resident #1 had another episode of diarrhea on 03/19/25.</p> <p>In an observation on 03/18/25 at 09:57 AM, CNA E and CNA F entered Resident #1's room to provide peri care. Both staff washed their hands and put on gloves CNA E unfastened the resident brief and she cleaned her front pubic area with several wipes. CNA E with the soiled gloves on she rolled the resident on her side by pushing her by the back, and the thigh. She removed the soiled brief and discarded it. CNA F held resident. CNA E removed and discarded her gloves, she sanitized hands and donned clean gloves, she wiped the anal area from front to back and then the buttocks, changing to a clean wipe with each swipe. CNA E removes gloves, sanitized hands, and donned clean gloves. She placed a clean draw sheet and brief under the resident. Both staff then rolled the resident over, and CAN F pulled the clean sheet under the resident. the staff closed the resident brief, repositioned her in bed, and covered the resident. Both staff then removed their gloves and washed their hands.</p> <p>In an interview on 03/18/25 at 10:10 AM, CNA E stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA E stated she contaminated Resident #1's shirt when she pushed her by her back with soiled gloves. CNA E stated failing to provide proper care exposed the resident to infections. CNA E stated she did not realize she had soiled gloves on when she pushed resident to turn her on the side.</p> <p>11-Record review of Resident #59's quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), hypertension (High blood pressure), anxiety disorder, and non-pressure chronic ulcer right foot (a persistence open sore or wound that develops on the skin, often on the legs .). Resident#59 has a BIMS score of 01/15 indicating sever cognitive impairment. Her Functional Status reflected she was dependent on staff for toileting hygiene including incontinent care.</p> <p>Record review of Resident #59's care plan, dated 02/02/25, reflected she Focus. ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: wounds. Goal. Will be free from complications related to infections through the review date. Interventions/Tasks. Use Enhanced Barrier Precautions.</p> <p>Record review of Resident #59'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 status.</p> <p>Record review of Resident #59's physician orders reflected an order dated 03/20/25: Monitor each shift for nausea, vomiting, diarrhea. Notify MD for any of the symptoms.</p> <p>Record review of Resident #59's physician orders reflected an order dated 03/18/25: Zofran oral tablet 4 mg give by mouth every 4 hours as needed for nausea, and vomiting.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #59's physician orders reflected an order dated 03/18/25: Imodium A-D oral tablet 2 mg give by mouth every 6 hours as needed for diarrhea.</p> <p>e-MAR review for Resident#59 dated 03/18/25 through 03/24/25 reflected, Resident#59 was not administered Zofran and Imodium tablets.</p> <p>Record review of Resident #59's Tasks titled Bowel movement/Bowel continence dated 03/17/25 through 03/24/25 reflected Resident#59 had 2 episodes of loose stool/diarrhea on 03/18/25, and 4 episodes of loose stool/diarrhea bowel movement on 03/19/25.</p> <p>Observation on 03/18/25 at 11:01 AM, of Resident #59's incontinent care, provided by CNA A, revealed CNA A washed hands and donned gloves and no gown. There was a signage and supplies for EBP outside of the Resident#59's room at the left side of the entrance.</p> <p>Interview on 03/18/25 at 11:20 AM, CNA A stated Resident #59 has a wound and that way there was a signage and the supplies for EBP in front of the room. CNA A stated she forget to wear required PPE when she went to provide incontinent care for Resident#59. CNA A the risk to resident development of infection. CNA A stated she had been in serviced on EBP.</p> <p>Record review of of CNA A's competency skills revealed she was competent in prevention and control of infections and donning and doffing PPE .</p> <p>12-Record review of Resident #277's Comprehensive MDS assessment dated [DATE] reflected she was an 84 -year-old female admitted to the facility on [DATE] with diagnoses included pressure ulcer of sacrum, dementia, and cognitive communication deficit. Resident #1's BIMS score of 15, which indicated Resident #277's cognition was intact, Resident #277 was always incontinent of bowel and bladder.</p> <p>In an observation of wound care on Resident #277 by ADON J on 03/19/25 at 12:06 PM, revealed Resident #277 was on Enhanced barriers precautions. There was signage on the right side of the door that informed visitors/staff she was on enhanced barriers precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. ADON J placed gauze, pair of scissors, a calcium alginate dressing (a soft comfortable, highly absorbent dressing), wound cleanser and dry dressing on the bed side table after she cleaned it. ADON J entered the resident's room without any form of PPE, there was PPE cart outside the door of the room. She washed her hand and donned clean gloves and she proceeded to wound care for Resident #277 without wearing gown. She performed wound care without other concerns, she washed hands and left the room.</p> <p>In an interview with ADON J on 03/19/25 at 12:30 PM, she stated she was supposed to wear gown and gloves when providing wound care to resident on enhanced barrier precaution and stated she had failed to do that. She stated failing to wear the proper PPE during wound care created a risk of cross contamination.</p> <p>13-Record review of Resident #28's Quarterly MDS assessment dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die), dementia, and need for assistance with personal care. Resident #28's BIMS score of 3, which indicated Resident #28' cognition was severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #28's nurse's note dated 03/17/25 at 11:46 PM, reflected, Vomiting x1 noted. Medical doctor notified.</p> <p>Record review of Resident #28's nurse's note dated 03/11/25 at 6:56 AM, reflected, Resident had episode of diarrhea. Medical doctor gave new order to initiate as needed standing order for Imodium 2 mg by mouth. Administered x 1 for diarrhea. Will continue to monitor.</p> <p>Record review of Resident #28's POC Response History (CNAs documentation in the resident's chart) revealed Resident #28 had one episode of diarrhea on 3/18/25 at 7:07 AM.</p> <p>Interview on 03/20/25 at 8:59 AM, with CNA F revealed she worked on 03/18/25 on the 6 AM to 2 PM shift on hall 100. She stated Resident #28 had diarrhea when she changed her in the morning. She stated she reported it to the nurse.</p> <p>Interview on 03/20/25 at 8:59 AM, with LVN I revealed on 03/18/25 in the morning she was told by the CNA F that Resident #28 had diarrhea. She stated she notified the physician and received order to give Imodium and to continue to monitor for symptoms.</p> <p>14-Record review of Resident #63's quarterly MDS assessment dated [DATE] reflected she was a 75-year-old female admitted to the facility on [DATE] with diagnoses included hypertension (elevated blood pressure), osteoarthritis and bipolar disorder. She was cognitively impaired.</p> <p>Review of Resident #63's nurse's note dated 03/18/25 at 6:55 AM, revealed Resident #63 had episode of diarrhea. Medical doctor gave new order to initiate as needed standing order for Imodium 2 mg by mouth. Administered x1 for diarrhea. Will continue to monitor.</p> <p>Record review of Resident #63's POC Response History (CNAs documentation in the resident's chart) revealed Resident #63 had one episode of diarrhea on 3/18/25 at 6:48 AM, and at 6:28 PM and on 3/19/25 at 4:11 PM.</p> <p>Interview on 03/20/25 at 8:59 AM, with CNA F revealed she worked on 03/18/25 on the 6 AM to 2 PM shift on hall 100. She stated Resident #63 had a large loose stool when she changed her in the morning. She stated she reported it to the nurse.</p> <p>Interview on 03/20/25 at 8:59 AM, with LVN I revealed on 03/18/25 in the morning she was told by the CNA F that Resident #63 had diarrhea. She stated she notified the physician and received order to give Imodium and to continue to monitor for symptoms.</p> <p>In an interview with the DON on 03/18/25 at 12:53 PM, she stated she was aware that some residents had symptoms of diarrhea, nausea and vomiting since last night. She stated nurses notified the physician and received order for medication and monitoring. She stated the facility do not isolate residents with symptoms of diarrhea and vomiting if they had less than 3 episodes in 24 hours.</p> <p>In an interview with the Medical Director on 03/18/25 at 03:05 PM, he stated the nurse called him yesterday to report residents with gastrointestinal symptoms (diarrhea, vomiting and nausea). He stated, Norovirus going around. He stated he treated symptoms with medication, and he stated residents with symptoms should isolated, and not eating in the dining with other residents. He stated isolation is a standing order for the facility to prevent spread of the infection.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In a follow up interview with the DON on 03/18/25 at 03:47 PM, she stated if a resident had symptoms of diarrhea, nausea and vomiting the staff would monitor, follow doctor's orders, and follow facility protocol which was to isolate resident if having more than 3 episodes of diarrhea.</p> <p>In an email from the Administrator on 03/18/25 at 3:05 PM, reflected the following residents had nausea/vomiting/diarrhea symptoms: Resident#8 and #41- as of the end of the day of 03/19/25 there were no additional residents, and one employee, CNA N, was out sick.</p> <p>In an email from the Administrator on 03/20/25 at 9:23 AM, reflected the following residents had nausea/vomiting/diarrhea symptoms was Residents #6, #10, #11, #15, #19, #20, #27, #28, #44, #50, #54, #60, #63, #66, #71, #73, and the physicians, including the Medical Director, had been notified and orders were given for Zofran 4 mg every 4 hours as needed, for vomiting/nausea and Imodium 2mg as needed for diarrhea episode. Further review revealed Resident #7 and Resident 48 was not included in tracking list.</p> <p>In a phone interview on 03/20/25 at 10:58 AM, CNA N revealed she was out sick and she denied having any ga [TRUNCATED]</p>		

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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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on observation, and interview the facility failed to ensure the call system was within reach of the resident, and accessible to a resident lying on the floor for 2 Residents' rooms bathroom (room [ROOM NUMBER] 302, room [ROOM NUMBER] 303) of 6 residents' rooms bathrooms reviewed for residents' call systems.</p> <ul style="list-style-type: none"> - The facility failed to ensure the call light system was accessible to a resident lying on the floor in the residents' toilets located in the secured unit room [ROOM NUMBER] 302 - The facility failed to ensure the call light system string was not missing, and was accessible to a resident, including a resident lying on the floor in the residents' toilets located in the secured unit room [ROOM NUMBER] 303 <p>This failure could place residents in the facility at risk of being unable to have a means of directly contacting caregivers.</p> <p>Findings included:</p> <p>room [ROOM NUMBER] 302</p> <p>-Observation on 03/18/25 at 09:55 AM resident toilet call light pull string was entwined on grab bar fixture next to the toilet. The grab bar was fixed to the wall two feet from the floor.</p> <p>Rooms: 3 303</p> <p>-Observation on 03/18/25 at 09:56 AM Residents toilet call light pull string was missing, and the call light outlet did not have a push button.</p> <p>Interview on 03/19/25 beginning at 09:02 AM the maintenance supervisor looked at the call light in both toilets, and stated he will fix it. The maintenance supervisor stated it was his responsibility to make sure the call light in the residents' rooms and bathroom were fixed and working. He stated the missing call light string, or not within reach of resident lying in the floor could cause resident not to call for help and fall.</p> <p>Interview on 03/22/25 at 4:53 PM the DON stated any issue with the call light not functioning should be report to the maintenance supervisor and fixed. She stated the risk to residents the inability to call for assistance and make needs met.</p> <p>Interview on 03/22/25 at 5:16 PM the Administrator stated any issue with the call light not functioning should be report to the maintenance supervisor and fixed. He stated the risk to residents the inability to make their needs know.</p> <p>Review of facility's policy Call Light/Bell revised 05/2020 reflected the policy of this facility to provide the resident a means of communication with nursing staff .Procedures: 1. Answer the light/bell within a reasonable time .</p>		