STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676351	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Discovery Village at Southlake	201 Watermere Drive Southlake, TX 76092

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676351	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Discovery Village at Southlake	201 Watermere Drive Southlake, TX 76092

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 0656 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 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 of 5 residents (Resident #1) reviewed for care plans. The facility failed to develop a care plan to address Resident #1's needs as follows:1. Stage 2 wound on his bottom (pressure ulcer)2. Right heel edema (leg swelling)3. Bowl movement changes due to ileus (this is temporary slowing or cessation of intestinal movement)4. Disease process Colitis (this is inflammation of the colon which may cause abdominal pain, diarrhea and sometimes blood in stool)5. Use of high blood pressure medication Lisinopril6. Lower urinary tract symptoms due to benign prostatic hyperplasia (urinary difficulty due to enlarged prostate)7. Use of blood thinner Enoxaparin for prevention of blood clot formation and Aspirin for coronary artery dieses (this is a disease that causes blockage of the main blood vessels that supply blood to the heart. These failures could place residents at risk of not having their needs identified and met. The findings were: Record review of Resident #1's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included high cholesterol, essential (primary) hypertension (high blood pressure), enlarged prostate with lower urinary tract symptoms (urinary difficulty due to enlarged prostate), unspecified diarrhea, ileus (this is temporary slowing or cessation of intestinal movement), colitis (this is inflammation of the colon which may cause abdominal pain, diarrhea and sometimes blood in stool), orthopedic after care, and abnormalities of gait and mobility, atherosclerotic heart disease of native coronary artery without angina pectoris (this is a disease that causes hardening and narrowing of arteries). Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 12, which indicated moderate cognitive impairment. Resident # had diagnoses which included Diarrhea, gastroenteritis (inflammation and irritation of the stomach lining) and colitis. Resident #1 required a walker and a manual wheelchair. Resident #1 required partial/moderate assistance for toileting and lower body dressing and supervision for upper body dressing, personal care and rolling left to right in the bed. Record review of Resident #1's physician order for October 2025 reflected the following: - cleanse open stage 2 wound to bottom with normal saline, pat dry and apply calcium alginate, cover with dressing daily and PRN one time a day for pressure ulcer. Ordered on 10/09/25.- May use air mattrass r/t pressure sore every shift for wound healing. Ordered on 10/20/25.- Monitor Left knee Surgical incision Q Shift. every shift for incision. 0rdered on 10/03/25-2 pillows under the Right heel 2 hours two times a day for edema ordered 10/11/25.-Aspirin enteric coated, by mouth, Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day related to atherosclerotic heart disease. Ordered on 10/05/25.-Diphenoxylate-Atropine Oral Tablet 2.5-0.025 MG (Diphenoxylate w/ Atropine) Give 2 tablet by mouthevery 12 hours as needed for diarrhea. Ordered 10/04/25.-Finasteride Oral Tablet 5 MG (Finasteride) Give 2 tablets by mouth one time a day for genitourinaryagents - miscellaneous (medication for bladder spasms). Ordered on 10/15/25. -Lisinopril Oral Tablet 10 MG (Lisinopril) Give 1 tablet by mouth one time a day related to essential(primary) hypertension hold if SBP less than 110 or DBP 60 or hr 60. Ordered 10/05/25. Record review of Resident #1's MAR and TAR, dated 11/12/25, reflected Resident #1 was administered the following:-Imodium oral tablet 2 mg, give 1 tablet by mouth one time only for anti-diarrheal/probiotic agents until 10/08/2025 15:59[3:59 PM]. Imodium was administered on 10/08/25. -Enoxaparin Sodium Injection Prefilled Syringe Kit 40 MG/0.4ML (Enoxaparin Sodium) Inject 0.4 ml subcutaneously one time a day for DVY[T] (DVT is a blood clot that forms in the deep veins, most often in the legs) until 11/03/2025 15:00 [3:00 PM]. Resident #1 was administered daily enoxaparin sodium injections to prevent blood clots starting 10/04/25 through 10/21/25 at 08:00 AM. -Aspirin 81 mg was administered daily from 10/05/25 through 10/21/25 at 09:00 AM.-Lisinopril 10 mg was administered daily 10/04/25 through 10/21/25 at 09:00 AM. Blood pressures vitals were within acceptable reading above 110/60.-Finasteride Oral Tablet for benign prostatic was administered daily 10/04/25 through 10/21/25 at 09:00 AM.-cleanse open stage 2 wound to bottom with normal saline, pat dry and apply calcium alginate, coverwith dressing daily and PRN one time a day for pressure ulcer.-SHOWER days on TH-THU-SAT, during the 2-10 shift. one time a day every Tue, Thu, Sat for shower-Start Date-10/04/2025 1600 were completed 10/4/25 through 10/18/25 at 4:00 PM.-2 Pillows under Right Heel 2hrs two times a day for edema -Start Date- 10/11/2025 1700 [5:00 PM] until 10/21/25 -Monitor Left knee Surgical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676351	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Discovery Village at Southlake	201 Watermere Drive Southlake, TX 76092

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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676351	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Discovery Village at Southlake	201 Watermere Drive Southlake, TX 76092

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 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, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for accurate medical records. The facility failed to ensure accurately documented skilled nurse notes for Resident #1 on 10/16/25 when RN A documented Resident #1 was a female, he had a left hip fracture, was forgetful, had poor motor coordination, and had balance problems when standing. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information and could cause confusion about the residents' care and place residents at risk for harm due to inaccurate records. Findings include: Record review of Resident #1's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included high cholesterol, essential (primary) hypertension (high blood pressure), enlarged prostate with lower urinary tract symptoms (urinary difficulty due to enlarged prostate), unspecified diarrhea, ileus (this is temporary slowing or cessation of intestinal movement), colitis (this is inflammation of the colon which may cause abdominal pain, diarrhea and sometimes blood in stool), orthopedic after care, and abnormalities of gait and mobility, atherosclerotic heart disease of native coronary artery without angina pectoris (this is a disease that causes hardening and narrowing of arteries). Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 12, which indicated moderate cognitive impairment. Resident #1 required a walker and a manual wheelchair. Resident #1 required partial/moderate assistance for toileting and lower body dressing and supervision for upper body dressing, personal care and rolling left to right in the bed. Record review of Resident #1's care plan, initiated 10/20/25, was incomplete. Record review of skilled progress note, dated 10/16/25 at 5:44 PM, by RN A, reflected, The patient is in bed, alert and oriented. No s/s of discomfort noted. She was diagnosed with left hipfracture, s/p Left hemiarthroplasty. The incision is dry and well-approximated. No s/s of infection. She exhibitsgeneralized weakness related to her diagnosis. She needs max assistance with ADLs. She is participating inskilled nursing services for rehabilitation. She is making good progress. During an interview with Resident #1's family on 11/12/25 at 9:47 AM, revealed on departure from the facility they requested Resident #1's records. She said the facility documented a different resident in the skilled notes, dated 10/16/25. She stated Resident #1 did not have a left hip fracture. In an interview with RN A on 11/12/25 at 1:30 PM, revealed he took care of Resident #1 while in the facility. He said he did not know why he documented the wrong information in Resident #1 chart. He said the facility had a high turnover of residents, and he may have mistakenly entered the notes while thinking of a different resident. He said it was an honest mistake. He said record accuracy was important for treatment decisions. In an interview with the DON on 11/12/25 at 5:01 PM, revealed he was not aware of the inaccurate record sent at discharge. He said the expectation was when documenting to have the right patient in front of you while documenting. He said it was important to keep an accurate record, so the correct treatments were given. He said the risk was record discrepancy. He said he would complete a one-on-one in-service. In an interview with the ADM on 11/12/25 at 5:50 PM, he said he expected the nurses to correctly input residents' records. He said he was not aware of an inaccurate record sent at discharge. He said he expected all staff to follow the facility policies and in-services would be completed. Record review of the facility's Charting and Documentation policy and procedure, revised July 2017, reflected: Service Standard: All services provided to the resident, progress toward care plan goals, or changes in the resident's medical, physical, functional, or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the intradisciplinary team regarding the resident's condition and response to care.