

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Park View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 View St Fort Worth, TX 76103	

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 0600</p> <p>Level of Harm - 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** 43791</p> <p>Based on interviews and record reviews the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 4 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to ensure Resident #1 had the right to be free from abuse when Resident #2 struck him in the face on 02/18/25.</p> <p>This failure could place residents at risk of injury and anxiety.</p> <p>Findings included:</p> <p>Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, stroke, and amputation of left leg.</p> <p>Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 9 indicating moderate cognitive impairment. The MDS reflected Resident #1 had no issues with verbal or physical aggression.</p> <p>Record review of Resident #1's care plan, dated 11/20/24, reflected he had cognitive impairment, visual impairment, and ADL self-care deficit.</p> <p>Record review of Resident #2's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included a traumatic brain injury causing fluid buildup in the brain requiring drainage via a shunt. Schizoaffective disorder, drug abuse, and violent behavior.</p> <p>Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 3, indicating severe cognitive impairment. His Behavioral assessment reflected no behavioral issues.</p> <p>Record review of Resident #2's care plan, dated 12/19/24, reflected he had a cognitive impairment related to his brain injury, he had behavioral issues of name calling of staff, and he was on a psychotropic medication.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's Behavioral Monitoring for January and February 2025 reflected on 1/5/25 he made accusations towards another resident, and on 1/25 he made complaints about another resident. No physical aggression documented.</p> <p>Record review of the facility's Provider Investigation Report, completed by the Administrator on 02/19/25, reflected the following incident occurred on 02/18/25 at 11:00 AM:</p> <p>.While [Resident #1] was at the nurses' station eating a snack, [Resident #2] walked up to the nurses station to get a snack as well. [Resident #1] made a statement to [Resident #2] and [Resident #2] struck [Resident #1] on the left cheek with his closed fist .[Resident #1] had some redness to the left cheek area. Nurse applied ice to the affective [sic] area. [Resident #2] also had some ice to his right fist as a precautionary measure The residents were immediately separated and treated in their rooms which are on opposite ends of the hall. [Resident #1] states that he does not have any pain but stated that he did want to report this incident to the police. The physician was notified of hte incident as well as the responsible parties. Neither resident seemed to have been emotionally affected. [Resident #1] stated that he was not in any pain but an X-ray was ordered as a precautionary measure. The police were called regarding the incident as [Resident #1] requested [Resident #2] has a history of violent behavior. When this administrator interviewed him, he had no remorse for his actions. The police arrive at approximately 1 pm to interview both residents as well. The .Police Department took custody of [Resident #2] from the facility and took him to .Hospital for a mandatory detention for a mental health evaluation. He currently remains in a mandatory detention at the hospital and will not be returning to this facility. [Resident #1] states that he is doing fine. His X-ray results came back negative for any fractures. He has a new order for Ibuprofen 400 mg every 6 hours as needed. [Resident #1] did not have any negative outcomes from this incident and has limited recall of the incident as well It is confirmed that [Resident #2] struck [Resident #1]. [Resident #2] was escorted by police to [the local hospital] for a mandatory detention and has been discharged from the facility and is not eligible to return. [Resident #1] continues to do fine and has no complaints of pain or anything else. The staff members were re-educated on the facility abuse and neglect policy as well.</p> <p>Record review of the Radiology Patient Report for Resident #1, dated 02/18/25, reflected: .No orbital fracture is seen. No focal bone lesion is present. The paranasal sinuses are normally aerated. No soft tissue abnormally is seen</p> <p>Record review of Resident #2's Progress Notes, dated 02/18/25 1:38 PM, written by LVN A reflected: Resident [#2] came to nurse's station asking for a cup of ice. Other resident [#1] was sitting in his w/c at nurse's station with his snack on the counter where resident was standing. Other resident [#1] thought resident [#2] was about to take his snack and began saying No .no .no loudly. Resident [#2] then said F*** You! and hit other resident [#1] in the face with his fist, other resident [#1] fell out of wheelchair. Staff was trying to get to the residents before it got to this point but it happened so quickly. Resident [#2] states I don't try to be mean, but people keep f***ing with me Resident [#2] was immediately escorted to his room by male CNA. Other resident [Resident #1] was immediately assessed for injuries</p> <p>Record review of the facility's In-Service Immediate Notification report, dated 02/18/25, reflected the facility provided staff with in-service training regarding abuse, neglect, and exploitation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/20/25 at 11:00 AM with LVN A revealed she was at the nurses' station when Resident #1 rolled up in his wheelchair to look at the snacks. Resident #2 walked up to the desk and stood in front of the snack tray. Resident #1 said no, no. no and Resident #2 turned and struck Resident #1 in the face with a closed fist. LVN-A stated she separated the residents to their rooms, placing Resident #2 on 1:1 supervision. Resident #1's right eye was red, and she applied ice to it. Resident #2 was given ice for his hand. She stated the DON and Administrator were notified.</p> <p>Interview on 02/20/25 at 11:05 AM with Resident #1 revealed he was trying to get a snack when Resident #2 blocked him. When he told him no to do that, Resident #2 punched him in the eye. Resident #1 stated he had never had an issue with Resident #2 prior, and now that he was gone he had no fear of concerns about his safety. Resident #1 stated he wanted to press charges because it wasn't right.</p> <p>Interview on 02/20/24 at 11:15 AM the DON stated since Resident #1 wanted to press charges the police department was called. After the police investigated, they placed Resident #2 in cuffs and took him away. The DON stated she did not know where Resident #2 had been taken until the hospital called the next morning to return the resident. The DON stated if the hospital had made medication changes, they had not given them enough time to take affect and she felt Resident #2 was still a risk to the other residents. She contacted corporate administration and they agreed the resident was a risk to other residents. An emergency discharge was initiated. The DON stated there had been no physical violence with Resident #2, he was only verbally 'grumpy with staff. She stated it had been noticed in the last few weeks after the resident had run out of cigarettes. The DON stated Resident #2's family had not responded to phone calls to bring him more cigarettes. She stated Resident #2 was started on a nicotine patch to help him out.</p> <p>Record review of the facility's Abuse, Neglect, and Exploitation policy, dated 09/06/24, reflected:</p> <p>It is the policy of this facility to provide protections for the health and welfare of each resident by developing policies and procedures that prohibit and prevent abuse, neglect, and exploitation.</p> <p>.VI. Protection of Resident</p> <p>The facility makes efforts to e sure all residents are protected from physical and psychosocial harms well as additional abuse.</p> <p>A Respond immediately to protect the alleged victim.</p> <p>B, Physical exam of the alleged victim for any sign of injury</p> <p>C. Increase supervision of the alleged victim and residents</p> <p>D. Room or staffing changes if necessary</p> <p>E. Protect from retaliation</p> <p>F. Provide emotional support and counseling to the resident .</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791</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 5 residents (Resident #3) reviewed for dental care.</p> <p>The facility failed to assist Resident #3 obtain a follow-up appointment with the Dentist for a root canal by failing to ensure payment was made to the Dentist.</p> <p>This failure could cause the resident unnecessary dental pain.</p> <p>Findings included:</p> <p>Record review of Resident #3's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included vehicle accident causing a brain bleed and subsequent build up of fluid in the brain, seizures, and lack of coordination.</p> <p>Record review of Resident #3's quarterly MDS, dated [DATE], reflected a BIMS score of 7 indicating he had severe cognitive impairment. His Functional Ability assessment indicated he was independent with his ADLs.</p> <p>Record review of Resident #3's care plan, dated 01/12/25, reflected he was at risk of further decline in his cognition, and was a fall risk related to impaired visual function.</p> <p>Interview on 02/19/25 at 10:08 AM with Resident #3 revealed he had pain to his upper front teeth on the right side of his mouth. He stated he received pain pills twice a day for the pain, so it did not really bother him. Resident #3 was unable to rate his pain on a 1-10 scale. He stated it was not bad. Resident #3 stated it did not affect his ability to eat. He stated he had seen the Dentist a long time ago but would like to see him again to resolve the issue.</p> <p>Observation on 02/19/25 at 12:00 PM revealed Resident #3 eating his noon meal, which consisted of hot and cold foods, with no obvious discomfort.</p> <p>Record review of Resident #3's EHR reflected a nursing progress note, dated 10/07/24, which reflected Resident #3 was seen by the Dentist. The Dentist addressed pain and sensitivity to his teeth and fillings were done. The resident was made aware that if pain continued he might need a root canal.</p> <p>Record review of a Social Work progress note, dated 11/22/24, reflected: Resident was seen for urgent assessment on 10/07/24 and the Dentist is awaiting on the invoice for admin approval.</p> <p>Interview on 02/19/24 at 12:30 PM with the Social Worker revealed she did not know what she meant about an invoice mentioned in her note from 11/22/24. She stated she would have to research it.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/19/24 at 1:05 PM with the Social Worker revealed the Dentist had submitted an invoice for \$843 for his visit on 10/07/24 that had not been paid. The Dentist would not see the resident again until the invoice had been paid. The Social Worker stated the invoice had just been paid, and she would put the resident on the list to see the Dentist for the next visit. The Social Worker stated she should have followed up sooner on the invoice in order not to delay Resident #3's dental care.</p> <p>Record review of the facility's Special Needs policy, dated 10/24/22, reflected:</p> <p>This policy pertains to the following needs: parenteral fluids, respiratory care, prostheses, dialysis, dental, podiatry, and vision.</p> <p>.3. If necessary the facility will assist residents in making appointments with a qualified person or facility and arrange for transportation to and from such appointments.</p> <p>4. The facility will communicate relevant information with outside providers to ensure safe, continuous care of the resident .</p>		