STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455606	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Care Center	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)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interviews and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for 1 of 3 residents (Resident #2) reviewed for medically related social services. The facility failed to ensure Resident #2's colonoscopy referral was followed-up on to ensure an appointment was scheduled for her to receive the procedure. This deficient practice could place residents at risk for their medical needs not being met and a decreased quality of life. Findings included: Review of Resident #2's Admission Record, dated 04/24/25, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #2's Quarterly MDS Assessment, dated 03/11/25, reflected she had a BIMS score of 15, indicating no cognitive impairment. Her active diagnoses included diabetes mellitus (a group of diseases that affect how the body uses blood sugar), cerebrovascular accident, transient ischemic attack, or Stroke, and Non-Alzheimer's Dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities). Review of Resident #2's care plan reflected it did not address her need for a colonoscopy or outside medical services. Review of Resident #2's Physician's Orders Summary Report, dated 04/24/25, reflected the following: GI Consult- Colonoscopy with an order date of 11/14/24. Review of Resident #2's Progress Notes reflected the following: Received order from Np [sic] fro [sic] GI consult-colonoscopy and also mammogram screening. Communication slip was sent to social services. Written by LVN A on 11/14/24 at 2:37 PM (continued on next page)

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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Communication Forms revealed there were not any about her colonoscopy appointment or referral. Review of packets of Resident #2's faxed clinicals submitted to an outside provider, dated 01/31/25, 02/16/25, and 02/20/25 reflected the contents of the packet were submitted requesting a consultation for her colonoscopy. Interview on 04/24/25 at 9:03 AM with Resident #2 revealed she was told she was going to have a colonoscopy done a few months ago but never had an appointment scheduled. Resident #2 said she had it recommended to her by the NP, and she never heard about when her appointment was going to be. Resident #2 said she was not sure who was scheduling it for her. Interview on 04/24/25 at 10:02 AM with the Social Worker revealed the Social Worker Assistant handled all the outside provider appointments for the residents. The Social Worker said she did not know anything about Resident #2's colonoscopy appointment. Interview on 04/24/25 at 10:12 AM with the NP revealed she wrote an order for Resident #2 to receive a colonoscopy screening since she was over the age of [AGE] years old. The NP said she was responsible for adding the order for the referral and then she communicated with the nursing department about it. The NP said normally she had to sign a communication form that was provided to the social services department for them to send the referral out for the appointment. The NP said she never heard anything back from the nursing or social services department about the referral or appointment for Resident #2's colonoscopy. The NP said she was not sure if Resident #2 ever had her appointment scheduled or not. Follow-up interview on 04/24/25 at 10:23 AM with the Social Worker and the Social Worker Assistant revealed the NP was responsible for creating the consult order, the nursing department was responsible for giving the order to the social services department, and the Social Worker Assistant was responsible for sending the referral with all the resident's clinicals to the provider and making sure the appointment was scheduled along with transportation. The Social Worker Assistant said when she had not heard back from the outside provider about the scheduled appointment, she called the provider to follow-up. The Social Worker Assistant said she sent off the referrals for Resident #2's colonoscopy a few months ago and never heard back from the outside provider. The Social Worker Assistant said she usually called the provider to follow-up but had no documentation of when or if this was done regarding Resident #2's colonoscopy appointment. The Social Worker Assistant said she still had the packets that were faxed to the outside provider for Resident #2 with all the dates of the confirmation of the faxes but had no other documentation on the matter. The Social Worker Assistant said she would have been the one responsible for following up with the outside provider and getting Resident #2's colonoscopy scheduled for her. Interview on 04/24/25 at 11:11 AM with LVN A revealed whenever the NP would write an order for a consult for a resident, she would write the information on a communication slip and give it to the social services department. LVN A said then the social services department usually took over and communicated with the provider to schedule the appointment. LVN A said she remembered filling out a communication slip and giving it to the social services department a few months ago but never heard anything else about it. LVN A said she was not sure if Resident #2 had her colonoscopy appointment yet or not but did not believe so. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/25 at 1:41 PM with the DON revealed the nursing department only received information about a scheduled appointment when the social services department arranged transportation for one. The DON said the social services department was responsible for making outside provider appointments after receiving a referral/request/order from the nursing department through the NP. The DON said she expected the social services department to continue to follow-up to make sure an appointment was scheduled. The DON said all staff had been trained for their part of their jobs and responsibilities, including the Social Worker and the Social Worker Assistant. The DON said outside provider appointments were discussed during morning clinical meetings between the nursing and social services departments. The DON said depending on what the outside provider appointment was for, there were lots of things that could happen if a resident's appointment was never scheduled. Interview on 04/24/25 at 2:29 PM with the Administrator revealed he heard from staff the system needed to be improved on how the social services department followed up on outside provider appointments. Review of the facility's Special Needs policy, dated 02/01/25, reflected: .3. If necessary, the facility will assist residents in making appointments with a qualified person or facility, and arranging for transportation to and from such appointments. 4. The facility will communicate relevant information with outside providers to ensure safe, continuous care of the resident

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #1) observed for infection control. The Wound Care Nurse failed to wear a gown while providing care for Resident #1, who was on enhanced barrier precautions. This failure could lead to the resident being exposed to infections from other residents. Findings included: Review of Resident #1's Admission Record, dated 04/22/25, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Review of Resident #1's Quarterly MDS Assessment, dated 01/28/25, reflected he had a BIMS score of 15, indicating no cognitive impairment. His active diagnoses included cellulitis of right lower limb (a common, potentially serious bacterial skin infection), lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), and chronic venous hypertension with ulcer of bilateral lower extremity (a condition where blood pressure inside the veins in a leg is high). Review of Resident #1's care plan, initiated 11/09/24, reflected the following: Focus: The resident requires Enhanced Barrier Precautions d/t Vascular ulcer . Observation and interview on 04/22/25 at 9:28 AM revealed she was preparing to provide wound care to Resident #1 outside of his door in the hallway. Outside of Resident #1's doorway was a sign that alerted those entering the room the resident was on enhanced barrier precautions. The sign reflected: Providers and staff must also: wear gloves and a gown for the following High-Contact Resident Care Activities Wound Care: any skin opening requiring a dressing. Resident #1 was in his room sitting in his wheelchair. The Wound Care Nurse said the Wound Care Nurse Practitioner was at the facility this morning and debrided Resident #1's wound so she was just applying the bandage treatment to the wound now. The Wound Care Nurse gathered her supplies, entered Resident #1's room, washed her hands, donned gloves, and began to apply the bandage to Resident #1's leg. The Wound Care Nurse applied the bandage without donning a gown. Observed in the room was a three-drawer bin that yellow disposable gowns could be seen inside of each drawer. The Wound Care Nurse explained that she was going to also wrap Resident #1's legs with a bandage because due to his lymphedema, his leg swelled and would begin to weep, and this would help keep that from happening. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/22/25 at 9:29 AM with the Wound Care Nurse revealed she did not think Resident #1 was on isolation precautions, such as enhanced barrier precautions. She said if Resident #1 had wounds he would be on enhanced barrier precautions, and she would then need to wear a gown and gloves to provide care to him. She said she only put on gloves to complete Resident #1's wound care just now and did not wear a gown. She said the DON made the decision if a resident was on enhanced barrier precautions or not. Follow-up interview on 04/22/25 at 12:11 PM with the Wound Care Nurse revealed when the state surveyor asked her about the enhanced barrier precautions sign posted outside Resident #1's door, she realized she forgot to put a gown on. She said Resident #1 was on enhanced barrier precautions, so she should have put on both gloves and a gown. She while she did put gloves on, there were gowns in the three-drawer bin inside his room she should have put on. She said she had been trained before on enhanced barrier precautions for residents. Interview on 04/22/25 at 1:47 PM with the ADON, who was the facility's Infection Preventionist, revealed Resident #1 had a wound on his lower right leg and was on enhanced barrier precautions. The ADON said all staff were aware Resident #1 was on enhanced barrier precautions and knew to wear a gown and gloves if they were caring for him. She said there was a sign posted on the outside of Resident #1's door alerting staff that the resident was on enhanced barrier precautions as well as a three-drawer bin inside his room that had gowns in it. She said if the Wound Care Nurse was providing wound care to Resident #1, she should have donned a gown to provide care. She said the purpose of this was to protect the residents since they were vulnerable, extra measures needed to be made to keep them safe. She stated all staff were responsible for noticing the sign and putting on the appropriate PPE to care for a resident on enhanced barrier precautions. She stated the expectation was for staff to follow all infection control procedures. The ADON said not wearing the gown in the room of a resident, who had a wound and was on enhanced barrier precautions, was that put other residents at risk if the Wound Care Nurse came in contact with the wound and then went to another resident's room afterwards because she could be carrying the infection to others. Interview on 04/22/25 at 2:12 PM with the DON revealed Resident #1 was on enhanced barrier precautions and all staff knew to wear gloves and gowns to provide care to him. The DON said the ADON was the Infection Preventionist for the facility, and she was responsible for ensuring the facility staff were following infection control procedures. Review of the facility's Enhanced Barrier Procautions [sic] policy, dated 01/12/24, reflected: 1. Use of EBP: EBP must be used for residents with .chronic wounds or indwelling medical devices, regardless of MDRO status. EBP should be employed during high-contact resident care activities. 2. Implementation: Staff must don gowns and gloves during high-contact care activities for residents meeting the criteria for EBP.