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	07/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 had the right to be free from abuse when Resident #2 physically assaulted him on 07/10/25. This failure could place residents at risk for abuse. Review of Resident #1's admission Record, dated 07/15/25, reflected he was a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #1's Quarterly MDS Assessment, dated 06/04/25, reflected he had a BIMS score of 15 indicating no cognitive impairment. His active diagnoses included depression (a mood disorder that causes persistent feelings of sadness and loss of interest), heart failure (a condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and coronary artery disease (a disease that is caused by plaque buildup in the arteries that block blood supply to the heart). Review of Resident #1's undated care plan did not reflect anything related to the incident with Resident #2 on 07/10/25.Review of Resident #1's Psych notes, dated 07/10/25 reflected the following: Services: Comments: Provider was contacted by nursing staff due to patient being agitated after an alleged altercaiton [sic] with another resident. Per staff report, the patient was the victim. Hours after the incident patient remains agitated.Review of Resident #1's Progress Notes reflected the following: -LVN A on 07/10/25 at 4:12 wrote: This nurse heard some noise coming from the north hallway, on getting there, resident was agitated, talking in a loud voice, this nurse tried to calm him down to get what the problem is.Resident [sic] alleged that a mal peer from another hall hit him on the face and gave him a little finger cut.This [sic] nurse calmed the resident a bit down for him to leave the scene, resident was asked to go to his own hallway and the other peer was put on one on one monitor to prevent further altercation. This nurse took residentout [sic] to the smoke patio and waited until resident calmed down Resident [sic] was advised to stay in his room after smoking to prevent further altercation.-LVN A on 07/10/25 at 5:43 PM wrote: This nurse went back to resident to f/u up [sic] on pain, resident denied pain at this time, [NP B] gave a new order to put TAO on the cut on the resident [sic] face for 3 days.-the SSD on 07/10/25 at 6:53 PM wrote: SSD, SS Assistant and Facility BOM met with [Resident #1] when he came into SSD's office stating 'Another male resident just punched me in the face and the nurses are not doing anything about it.'With questioning, it was learned that the other male resident was laying in the floor in the dining room area like he prefers to do. [Resident #1] told him 'Hey let me help you get up, people are about to be coming thru here to smoke and you will be in the way.' Another male resident laughed and taunted the situation and the male resident on the ground punched [Resident #1] on the left cheek bone. Area has a larger than quarter size purple bruise forming with 2 cut areas.SSD questioned resident if he would like an ice pack and he refused. Facility Admin- Abuse Coordinator and ADON were notified of resident's statements. IDT was already aware of situation, resident assessments have been initiated. Other male resident has been placed on 1 on 1 supervision.SSD, SS Assistant and BOM spoke at length with [Resident #1] due to him being worked up stating 'The police are going to have to be called on me because I am going to take care of him for doing this. I don't care about going to jail.' [Resident #1] was educated on treating others the way he wants to be treated, facility rules for no aggression, what jail is like, how expensive it is to bond out, how much a fine could be, that this behavior would interrupt his desire to eventually move to another facility.Due to resident stating understanding in one breath and then returning to being worked up, [Psych NP] was notified. NP then spoke with Hallway Nurses where PRN Anxiety [sic] med Dr. Order was written.-the SSD on 07/11/25 at 4:17 PM wrote: SSD called [City Initials] PD Non-Emergency [phone number] and requested that a Patrol Unit be dispatched to [Facility Name] to meet with [Resident #1] in an attempt to speak with him, to get him to calm down after the physical altercation that he was in with another male resident yesterday. Interview on 07/16/25 at 8:45 AM with Resident #1 revealed he was lying in his bed watching TV. Resident #1 said Resident #2 was on the ground the other day and he was telling him he needed to get up. Resident #1 said he tried to help Resident #2 get up from the ground and then someone near them started talking back about something. Resident #1 said he turned his face to tell the other resident to be quiet and when he turned back to Resident #2, he punched him on the right side of his face. Resident #1 said it hurt and he was very upset about the situation, but he had calmed down since then. Resident #1 said he got a scratch on his face and had a bruise for a few days but it had since healed. Resident #1 said