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	11/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 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, observation, and record review, the facility failed to establish and 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 one (Resident #1) of three residents reviewed for infection control. The facility failed to ensure Resident #1, who was on enhanced barrier precautions for ESBL, received tracheostomy care via sterile technique. This failure placed all residents at risk for the spread of infections and decreased quality of life. Findings included:Record review of Resident #1's face sheet, dated 10/30/2025, reflected the resident was a [AGE] year-old female, admitted [DATE], re-admitted [DATE] from an acute care hospital. Her DX included, malignant (cancerous) neoplasm (tumor) of upper lung lobe, hemiplegia (paralysis on one entire side of the body), cerebral infarction (stroke), dysphagia (difficulty swallowing), aphasia (difficulty speaking), HTN (high blood pressure), COPD (severe shortness of breath), and diabetic mellitus type 2 (non-insulin dependent) with neuropathy (nerve damage to hands and feet), and depression. Record review of Resident #1's admission MDS assessment, dated 10/30/2025, reflected she had a BIMS score of 8, which indicated moderate cognitive deficit due to chronic (long standing) disease processes. Resident #1 stated she was sad because she was unable to eat solid food due to her tracheostomy. Record review of Resident #1's care plan, dated 10/30/2025, reflected the resident was at high risk for further impaired cognition due to BIMS of 8. Resident #1 has had impaired communication due to being edentulous (no teeth) and difficulty speaking due to tracheostomy status. Resident #1 requires required assistance with all ADLs due to right side weakness from a stroke. Resident #1 was at risk for psychosocial well-being due to a diagnosis of depression. Resident #1 was on enhanced barrier precautions due to colonization (bacteria of the body not causing harm) of ESBL. Resident #1 received O2 and suctioning PRN and tracheostomy care with oral care every nursing shift. Interview and observation with Resident #1 on 11/07/2025 at 9:25 AM, revealed the resident was awake and alert to person and event. She exhibited difficulty speaking due to a dx of aphasia, tracheostomy status, and being edentulous. Observation of tracheostomy care on 11/07/2025 at 9:30 AM, revealed LVN A did not set up all needed supplies prior to starting the tracheostomy care. A previously opened bottle of clear liquid was used instead of sterile saline, per policy, to soak gauze sponges as well as used with sterile 14 French (size of the suction tube) suctioning tube to suction Resident #1 to clear secretions. LVN A broke sterile field (the nurse contaminated her sterile gloves) during tracheostomy care by reaching into Resident #1's bedside table during care to retrieve supplies with her sterile gloves on. LVN A did not stop the care procedure after contaminating the sterile gloves. During an interview on 11/07/2025 at 10:00 AM, LVN A indicated she realized she broke sterile field when she reached into Resident #1's bedside table to retrieve supplies she failed to set up before beginning the tracheostomy care. The bottle of clear liquid was identified as a previously used saline container which was no longer sterile. When asked what a prudent nurse would do in this case, LVN A stated she should have stopped and began the tracheostomy care process from the beginning with fresh supplies. LVN A was asked what her expectations were of maintaining sterile field during a procedure that required it, especially with a resident on enhanced barrier precautions, LVN A replied to prevent further spread of bacteria from the resident to herself and other surfaces. During an interview on 11/07/2025 at 12:25 PM, the DON revealed she was employed at this facility for 2.5 months. The DON revealed tracheostomy care training was provided once per week and provided 1 to 1 training with the ADON the facility had a Respiratory Therapist that comes to the facility. The DON revealed the ADON then trained the nurses in tracheostomy care. The DON revealed on the days the RT was in house, the RT provided tracheostomy care. The DON stated she (meaning herself) observed the nurses provide tracheostomy care occasionally. The DON stated tracheostomy skill competency was checked annually by the RT. The DON stated all facility P & P were currently written by corporate staff and she had not reviewed the P & P for tracheostomy care or suctioning care. The DON revealed that a sterile field was necessary to prevent infection and the expectation of nurses that broke sterile field was to stop immediately and start over with all new supplies. On 11/10/2025 at 2:00 PM, a telephone interview was conducted with a Respiratory Consultant A. This contact stated she was a consultant for this facility, not employed as a respiratory therapist. The RC stated she was contracted with this facility for three months. The RC revealed she provided all tracheostomy care and suctioning training to staff nurses based on her 17-year hospital