

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/30/2026
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 (Residents #10) of 5 residents reviewed for call lights. The facility failed to ensure Residents #10's call lights were answered in a timely manner. This failure could place residents at risk for decreased quality of life, self-worth and dignity. Findings included: Record review of the quarterly MDS assessment dated [DATE] revealed Resident #10 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of central cord syndrome at unspecified of cervical spinal cord (common form of an incomplete spinal cord injury in the neck). Resident #10 was dependent on staff for toileting hygiene, upper and lower body dressing and personal hygiene. Resident #10's MDS revealed his cognitive function was completely intact with a BIMS score of 15. During an interview on 07/29/26 at 10:48 a.m., Resident #10 revealed he did have to wait a long time. Resident #10 stated that he requested a brief change at 8:00 a.m. but took so long for a staff member to come that he left the room for a smoke break at 9:00 a.m. Resident #10 stated that he did not have any skin breakdown. Resident #10 stated that he was able to use the restroom on his own but required a new brief as urine had gotten on it and wanted a new one. Resident #10 stated that his aide today was CNA A and nurse was RN D. Observation on 07/29/26 at 11:16 a.m., Resident #10 pressed his call light. State surveyor stayed in Resident #10 room until 11:57 a.m. Resident #10 call light remained on. CNA A entered Resident #10's room [ROOM NUMBER] minutes later at 12:11 p.m. Observation on 07/29/26 at 12:08 p.m., RN D exited a resident room, walked to the south nurses' station, then returned to the hall that Resident #10 resided on, RN D did not respond to the call light. During an interview on 07/29/26 at 2:15 p.m., CNA A stated that she had been employed at the facility for five years. CNA A stated that she was the aide for the south side of the building. CNA A stated that she was not aware that a call light took 55 minutes to answer as anyone in the building could answer a call light. CNA A stated that a call light was to be answered within five minutes. CNA A stated that no one should have to wait 55 minutes to be assisted with care and that could lead to skin breakdown. CNA A revealed if you could not assist the resident, you were supposed to go and get a staff member who could. CNA A stated that she received in-service on call light response two weeks ago. During an interview on 07/29/26 at 2:29 p.m., RN D stated that he had been employed at the facility for three months. RN D stated that he was the charge nurse for the south side of the building. RN D stated that he was unaware that a call light did not get answered for 55 minutes. RN D stated that he could not provide why it took 55 minutes to answer a resident call light. RN D stated that he had a call light response in-service. RN D stated that call light response should be prompt and prompt meant less than 15 minutes. RN D stated that the risk to residents when call lights were not (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	answered promptly could lead to skin breakdown, emotional neglect. During an interview on 07/30/26 at 2:14 p.m., the DON stated that she had been employed at the facility for 11 months. The DON stated she expected her staff to answer call lights timely. The DON said that she wanted all staff to answer call lights and if they could not take care of the problem, they needed to get someone who could. The DON said the call light should never stay on longer than five to seven minutes and anything over that time was too long. The DON said there was no reason that the staff should not answer the call lights. The DON stated that the risk of call lights not being answered was lack of patient care, needs weren't attended to, decline of quality of life, safety concerns, falls, or skin breakdowns. Record review of facility in-service on Customer Service dated 07/06/26 through 07/08/26 covered Call System, Residents. Record review of the facilities June Grievance log revealed no issues with call light response time. Review of the Policy and Procedure Call System, Residents dated 09/2022, revised 01/2025, Residents are provided with a means to call staff for assistance through communication that directly calls a staff member or a centralized workstation. 6. Calls for assistance are answered timely		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 (#11) of 5 resident rooms (room [ROOM NUMBER]B) reviewed for accidents and hazards. The facility failed to ensure that a mechanical lift was locked when not in use in room [ROOM NUMBER]B. This failure could place residents, visitors and staff at risk of falls and/or injuries. Findings include: Record review of the quarterly MDS assessment dated [DATE] revealed Resident #11 was a [AGE] year-old male admitted to the facility on [DATE], readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infraction (hemiplegia is the total paralysis of one entire side of the body, while hemiparesis is mild to moderate muscle weakness on one side). Resident #11 had impairment on one side for his upper and lower extremities. Resident #11 was not able to walk. Resident #11's MDS revealed his moderate cognitive impairment with a BIMS score of 11. Observation of room [ROOM NUMBER]B on 07/30/26 at 10:25 a.m. revealed an unlocked and unsecured mechanical lift. During an interview on 7/30/26 at 10:35 a.m., LVN C stated that she was unaware of a mechanical lift in room [ROOM NUMBER]B on 07/30/2026. LVN C stated she could not state why the mechanical lift was left unattended and unlocked. LVN C stated all mechanical lifts were to always be locked and secure when they were not in use. LVN C stated that she would ensure that the mechanical lift was removed from room and placed in the storage room when not in use. LVN C stated that harm could be caused to anyone when a mechanical lift was unlocked, which included accidents and falls due to the unlocked and unsecured mechanical lift being moved and rolled. She stated that someone could be harmed by having a serious fall with injuries, such as someone's foot getting caught in the mechanical lift. LVN C stated that she had in-service training on mechanical lift usage in July 2026. During an interview on 07/30/2026 at 2:00 p.m., CNA B stated that she had been employed at the facility for three years. CNA B stated that she was the aide who used the mechanical lift in room [ROOM NUMBER]B. CNA B stated that she used the mechanical lift on the resident in bed A. CNA B stated that she could not state the reason the mechanical lift was left unattended and was unaware that it was unlocked. CNA B stated that the facility policy was when the mechanical lift was not in use it was to be placed in a storage room and locked. CNA B stated that a mechanical lift should not be left unattended in a resident's room. CNA B stated that the risk to residents and/or staff if left unattended and unlocked was that someone could trip and cause an injury. During an interview on 07/30/26 at 2:14 p.m., the DON stated that she had been employed at the facility for 11 months. The DON stated that she was unaware that a mechanical lift was parked inside room [ROOM NUMBER]B unlocked and unsecured on 07/30/26. The DON stated that her expectation for all staff at the facility was to ensure that all mechanical lifts in the facility were to be locked and secured when they were parked and not in use. The DON stated that all staff have been educated and trained on the proper usage and safety of mechanical lifts, which included always locking and always securing them. The DON stated that she could not recall when all staff received their last in-service training on mechanical lifts. The DON stated that she will reeducate staff with in-service training on mechanical lift safety and storage. The DON stated the facility designated area for storage for the mechanical lifts were in a storage room. The DON stated there was a risk of anyone in the facility to be injured due to an unlocked and unsecured mechanical lift. She stated the risk was that the resident and/or staff could bump against the unlocked mechanical lift and cause an accident. Record review of facility Transfer and Hoyer in-service dated 06/30/2026 covered Hoyers should be locked and stored appropriately when not in use.		