| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455606 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Care Center | 3301 View St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859<br><br>Based on observation, interview, and record review, the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 2 of 2 residents (Residents #82 and #109) reviewed for feeding assistance.<br><br>1. CNA A failed to maintain Resident #82's dignity and respect by standing while feeding the resident her lunch meal on 12/03/24 at 12:39 PM.<br><br>2. LVN B failed to maintain Resident #109's dignity and respect by standing while feeding the resident her lunch meal on 12/03/24 at 1:00 PM.<br><br>The failure could negatively affect the mental and psychological well-being of all residents who required the assistance of staff with eating.<br><br>Findings included:<br><br>1. Record review of Resident #82's Quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing) following nontraumatic intracerebral hemorrhage (complication of a brain bleed). Resident had severe cognitive impairment with a BIMS score of 05.<br><br>Record review Resident 82's care plan revised 07/05/2024 reflected: has an activity of daily living self-care performance deficit and is at risk for not having her needs met in a timely manner. Interventions: Eating: Supervised assist X 1 staff.<br><br>Observation on 12/03/2024 at 12:30 PM revealed CNA A stood beside Residents #82's bed in her room. She fed the resident while standing.<br><br>In an interview on 12/03/2024 at 12:39 PM, CNA A stated she did not know why she should not stand while feeding. She stated she only knew while helping with feeding in the dining room she was supposed to sit on a chair. She stated sitting helped to promote dignity. She stated she was not aware of the risk of standing while assisting with feeding, and she had not done training on assisting with feeding.<br><br>(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 |
|---|---|---|
| | | |

| 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 12/05/2024 |
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| NAME OF PROVIDER OR SUPPLIER Park View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3301 View St Fort Worth, TX 76103 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review of Resident #109's Quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of multiple sclerosis (chronic disease that affects the brain and spinal cord, causing the immune system to attack healthy nerve cells). Resident had severe cognitive impairment with a BIMS score of 00.<br><br>Record review Resident #109's care plan dated 12/23/2023 reflected the resident had an ADL self-care performance deficit and is at risk for not having her needs met in a timely manner. Intervention: Eating: extensive x1 .<br><br>Observation on 12/03/2024 at 01:00 PM revealed LVN B stood beside Resident #109 in the dining room. He was observed cutting and feeding the resident from her plate of food while standing.<br><br>In an interview on 12/03/2024 at 01:12 PM, LVN B stated he was supposed to be seated while assisting with feeding. He stated sitting helped to slow down the feeding and prevent aspiration. He stated he had not done training on being seated while feeding but he stated he knew he was supposed to sit.<br><br>In an interview on 12/05/2024 at 09:46 AM, the DON stated she expected staff to sit next to the residents and be on the same level when assisting them to eat, whether in their rooms or in the dining room. She stated sitting helped staff to go with the pace of the resident and the residents would not feel rushed. She said this would affect the resident's dignity. She said staff were trained on resident rights and dignity. She stated they do train on various subjects every Wednesday. She stated nurses were responsible of monitoring and supervising the dining room and in the resident's rooms. She stated the ADONs do spot checks.<br><br>Interview with ADON H on 12/03/24 at 10:53 AM revealed nurses were responsible of supervising the dining room and the rooms while residents were being fed. She stated staff should be seated face to face with residents to control the pace and promote dignity. She stated she sometimes monitored the dining, but nurses were responsible to monitor and supervise.<br><br>Record review revealed a copy of an in-service record with no title dated 12/03/2024, and LVN B and CNA A names were documented as being attendees of the training. The in-service training record reflected: Attention all staffs, when feeding the residents with feeding you are to be seated eye level with the resident. You can't stand to feed the residents, if they are able to get out of bed please do so if they are willing to.<br><br>Record review of the facility's Resident dignity policy, revised February 2020, reflected:<br><br>.It is the policy of the facility to promote care for residents in a manner and in an environment that maintains or enhances each residents' dignity and respect. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140<br><br>Based on observations, interviews, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 10 residents (Residents #26 and #34) reviewed for accommodation of needs.<br><br>1. The facility failed to ensure Resident #26's call light was placed within reach.<br><br>2. The facility failed to ensure Resident #34's call light was placed within reach.<br><br>These failures could place residents at risk of injuries and unmet needs.<br><br>Findings included:<br><br>1. Record review of Resident #26's face sheet, dated 12/05/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE].<br><br>Record review of Resident #26's quarterly MDS Assessment, dated 11/24/24, reflected her BIMS was not completed due to the resident was rarely/never understood. Her diagnoses included cerebral infarction, cognitive communication deficit, lack of coordination, hemiplegia (paralysis that affects one side of the body) and hemiparesis (partial paralysis or weakness) following cerebral infarction (stroke) affecting right dominant side, aphasia (language disorder), and muscle weakness. The MDS further revealed Section GG - Functional Abilities indicated the resident was totally dependent on staff to assist with self-care and mobility.<br><br>Record review of Resident #26's care plan, revised dated 10/11/24, reflected the following: Focus: Alteration in musculoskeletal status r/t contracture: right hand, right knee. Goal: Will remain free of complications related to contractures. Interventions: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Focus: Communication (Impaired): [Resident #26] has a communication problem related to her CVA . Aphasic and nonverbal. Goal: [Resident #26] will have needs met in a timely manner, dignity will be maintained, and current level of functioning will be maintained over the next 90 days. Intervention: Ensure/provide a safe environment: Call light in reach.<br><br>Observation on 12/03/24 at 10:47 AM revealed Resident #26 was lying in bed sleeping. Resident #26's call light string was not within reach. The call light string was attached to the call light switch located on the wall next to the resident's bed.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 12/04/24 at 3:47 PM with CNA F revealed she was the assigned CNA to Resident #26. CNA F stated all residents call lights should be within reach and it was the responsibility of all staff to ensure they were within reach. Observed CNA F entered Resident #26's room, the resident was in bed sleeping. CNA F observed the call light string and stated the call light string was not within reach. She stated any movement made the string fall from the bed. She stated even though Resident #26 did not use the call light it should always be within reach. She stated she completed her rounds and did not notice the call light string was not within reach. She stated the risk of not having the call light within reach would be that the resident might need help and would not be able to call for assistance.<br><br>2. Record review of Resident #34's face sheet, dated 12/05/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE].<br><br>Record review of Resident #34's quarterly MDS Assessment, dated 11/20/24, reflected her BIMS was not completed due to resident was rarely/never understood. Her diagnoses included heart failure, hypertension, reduced mobility, unsteadiness on feet, abnormal posture, and repeated falls. The MDS further revealed Section GG - Functional Abilities indicated the resident was totally dependent on staff to assist with self-care and mobility.<br><br>Record review of Resident #34's care plan, revised dated 09/24/24, reflected the following: Focus: Resident has impaired visual function. Goal: Resident will show no decline in visual function. Interventions: Anticipate needs and meet them as able. Keep call light in reach when in room or bathroom. Focus: The resident has the potential for falls related to gait/balance problems. Goal: The resident will be free of falls. Interventions: Anticipate and meet the resident's needs. Place items frequently used by the resident within easy reach when in the room.<br><br>Observation on 12/03/24 at 2:49 PM revealed Resident #34 was lying in bed sleeping. Resident #34's call light not within reach. The call light was underneath the end of her bed wrapped around the wheels of the bed.<br><br>Observation and interview on 12/04/24 at 3:42 PM revealed Resident #34 lying in bed sleeping, the call light was not within reach. CNA E stated she was the assigned CNA for Resident #34. Observed CNA E untangle Resident #34's call light from underneath the resident's bed. She stated the call light should always be within reach. She stated she was unaware how long the call light had been in that position. She stated it was the responsibility of the CNAs to ensure call lights were within reach. She stated if a resident's call light was not within their reach, the resident could need something and not be able to let anyone know.<br><br>Interview on 12/04/24 at 3:55 PM with LVN G revealed call lights should be within reach. She stated it was the responsibility of all staff to ensure call lights were within reach when residents were in the rooms. She stated the potential risk of not having the call light within reach could be that the resident would be unable to call for assistance.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 12/04/24 at 10:14 AM with the DON revealed her expectations were for call lights to be answered in a timely manner and to be within reach of the resident. The DON stated everyone in the building was responsible for ensuring the call light was within reach of the resident. She stated when rounds were made nursing staff should ensure call lights were within reach. The DON stated the potential risk with a resident not having a call light within reach was they could need something and not be able to ask for help.<br><br>Record review of the facility's Call light -Use of policy, revised 01/01/24, reflected the following:<br><br>It is the policy of this home to ensure residents have a call light within reach that they are physically able to access and that they have been instructed on it use.<br><br>.12. Be sure call lights are placed near the resident, never on the floor or bedside stand. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859<br><br>Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice for 1 of 1 resident (Resident #102) reviewed for oxygen orders.<br><br>The facility failed to administer oxygen for Resident #102 as ordered by the physician.<br><br>This failure could place residents at risk of receiving incorrect or inadequate oxygen support, resulting in a decline in health.<br><br>Findings included:<br><br>Review of Resident #102's quarterly MDS, dated [DATE], revealed the resident admitted to the facility on [DATE] with diagnoses including respiratory failure (when the lungs cannot release enough oxygen into blood preventing the organs from properly functioning). Resident #102 had intact cognition with a BIMS score of 13. He required oxygen therapy.<br><br>Review of Resident #102's Care Plan initiated on 04/24/24 reflected a care plan addressing respiratory illness with a goal that reflected: Resident will have no signs or symptoms of hypoxia through the next review date. Intervention administer oxygen therapy per physician's orders.<br><br>Review of Resident #102's physician order, dated 07/09/24, revealed the physician ordered the resident to be on 3 LPM. Inhalation every shift via nasal canula for respiratory failure.<br><br>Observation on 12/03/24 at 10:41 AM revealed Resident #102 on his bed sleeping using oxygen at 5 LPM continuous per nasal cannula.<br><br>Observation and interview on 12/03/24 at 1:10 PM revealed Resident #102 seated on his bed eating lunch. He was using oxygen at 5 LPM continuous per nasal cannula. Resident#102 was not sure how much oxygen he was supposed to be receiving.<br><br>Observation and interview on 12/03/24 at 3:17 PM with RN C revealed Resident #102 was on his bed using oxygen at 5L/min continuous per nasal cannula. RN C revealed she was assigned to take care of Resident #102. She was observed checking the orders and she revealed Resident #102 was supposed to be on 3 LPM of oxygen every shift. RN C stated the failure to administer as per the doctors' orders could predispose Resident#102 to having more oxygen, that could damage the lungs. She stated she had done training on oxygen administration.<br><br>Interview with the DON on 12/05/24 at 9:57 AM revealed all the nurses were expected to follow physician orders for oxygen therapy. The DON stated Resident #102 had many staff that does rounds in his room including from hospice and she expected them to have checked on his oxygen tank and rectify to correct amount of oxygen as per the doctors' orders. She stated she had done an in-service on following physician orders, but no training record was provided. The DON stated the failure to follow the orders would lead to hyperoxygenation and would affect the lungs. She stated the ADONs were responsible of auditing the orders and supervision.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with ADON H on 12/5/24 at 10:48 AM revealed she expected her staff to check on residents oxygen to ensure they were getting oxygen as per the physician orders at the start of every shift. She stated she went to Resident#102's room, but she did not check the oxygen when she was doing rounds. She stated excessive oxygen could cause lungs damage.<br><br>Review of the facility's Following Physician Orders policy, revised November 2017, reflectedd the following:<br><br>.C. Carry out and implement physician orders |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140<br><br>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 5 (Resident #26)residents reviewed for pharmaceutical services.<br><br>LVN D failed to follow the facility policy for flushing Resident #26's gastrostomy tube with 5-10 mL (or prescribed amount) of water before, between, and after medications, when she administered Vitamin D 125 mcg, Magnesium Oxide - mg supplement, and Sodium Chloride table 1 gm to the resident.<br><br>These failures could put residents who received medications via gastrostomy tube at risk for overload and aspiration.<br><br>Findings included:<br><br>Record review of Resident #26's face sheet, dated 12/05/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE].<br><br>Record review of Resident #26's quarterly MDS Assessment, dated 11/24/24, reflected her BIMS was not completed due to resident was rarely/never understood. Her diagnoses included cerebral infarction (stroke), cognitive communication deficit, lack of coordination, hemiplegia (paralysis that affects one side of the body) and hemiparesis (partial paralysis or weakness) following cerebral infarction (stroke) affecting right dominant side, muscle weakness, Vitamin D deficiency, aphasia (language disorder), and gastrostomy status. The MDS further revealed Section K -Swallowing/Nutritional Status indicated resident nutritional approaches were feeding tube.<br><br>Record review of Resident #26's care plan, revised dated 09/24/24, reflected the following: Focus: Feeding Tube/ nutritional status [Resident #26] requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Feeding tube is related to Dysphagia. [Resident #26] receives diabetasource (1) can 5 times per day with 120ml of water every 6 hours. patient is npo. Goal: Resident will be adequately nourished and remain within 5% of their ideal body weight for the next 90 days. Interventions: Dissolve each med with 5 ml of H2o and administer 10ml of H2o between each med. Administer tube feeding and water flushes as ordered.<br><br>Record review of Resident #26's physician orders reflected the following:<br><br>-Dissolve each med with 5 ml of H2O and administer 10 ml of H2O between each med. Every shift. Start date 04/28/21 7AM-3PM, 3PM-11PM, 11PM-7AM.<br><br>-Enteral Feed Order every shift Flush enteral tube with 30ml water pre/post medication administration and 5-10 ml water between each medication. Start date: 08/14/21 7AM-3PM, 3PM-11PM, 11PM-7AM.<br><br>- Vitamin D3 Tablet 125 MCG (5000 UT) (Cholecalciferol) Give 1 tablet via G-Tube in the morning related to Vitamin D Deficiency - Start Date 11/23/21 0900 (9AM)<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Sodium Chloride Tablet 1 GM Give 1 tablet via G-Tube three times a day for hyponatremia (low sodium levels) - Start Date 04/21/23 0900 (9AM), 1400 (2PM), 2000 (8PM)<br><br>-Magnesium Oxide -Mg Supplement Oral Capsule 400 MG (Magnesium Oxide (Mg Supplement)) Give 1<br><br>capsule via G-Tube in the morning for hypomagnesemia - Start Date 09/25/24 0900 (9AM)<br><br>Observation on 12/05/24 at 9:07 AM revealed LVN D prepared the following medication, crushed them, and placed them in separate cups:<br><br>-Vitamin D3 tablet 125 mcg<br><br>-Magnesium Oxide - mg supplement 1 capsule 400mg<br><br>- Sodium Chloride 1 tablet 1gm<br><br>LVN D did not dissolve the medication prior to administering to Resident #26. LVN D went to Resident #26's room, positioned the resident, checked for the g-tube placement and residual, and flushed the g-tube with 30 ml of water. LVN D poured the crushed Vitamin D medication, then poured 30ml of water, then poured the crushed magnesium medication, and then poured another 30 ml of water. The g-tube clogged due to the medication, LVN D tried to push the medication with a plunger. LVN D was unable to unclog the g-tube, LVN D was observed to empty the water, and medication that was in the syringe. She then added another 30ml of water and was able to unclog the g-tube. LVN D proceeded to provide the crushed sodium chloride medication, then poured another 30 ml of water. She then provided the rest of the magnesium medication that she had previously emptied out from the syringe. LVN D then provided Resident #26's bolus formula and was observed pushing the bolus formula with a plunger instead of gravity. LVN D failed to follow physician orders when flushing in between medications.<br><br>Interview on 12/05/24 at 10:06 AM with LVN D revealed she reviewed Resident #26's physician orders prior to administering her medications and feedings. LVN D reviewed Resident #26's physician order and stated she was not aware that the resident had an order to dissolve crushed medications and to flush 5-10ml of water in between medications. LVN D stated she did not dissolve the resident medication prior to administering and did not flush with the prescribed amount. LVN D stated magnesium medication took a while to dissolve and caused the g-tube to clog. She stated she tried to push the medication in, but she was not able too. She stated when providing medication and formula the flow should be via gravity. LVN D stated failure to check orders could lead to giving too much water and that could lead to fluid overload. She stated administering medication through plunging could cause the resident to have air in her stomach. She stated she had done training on medication administration via gastrostomy tube.<br><br>Interview with 12/05/24 10:14 AM with the DON revealed her expectation was for the nurses to follow the physician orders and check the orders before medication administration. The DON stated when administering medication via g-tube nurses were expected to check the order, crush medication, place them in individual cups, mix with water, and flush in between each medication. The DON stated nurses should administer medication, water flush and formula via gravity, and not plunging. She stated the risk would be causing gas, aspiration, and g-tube to clog.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's Medication - Treatment Administration and Documentation Guideline policy, revised 04/06/23, reflected the following:<br><br>To provide a process for accurate, timely administration, and documentation of medication and treatments.<br><br>.2. Verify administration accuracy by checking the medication with the EMAR three (3) times.<br><br>.4. Administer the medication according to the physician order |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791<br><br>Based on interview and record review, the facility failed to ensure residents were not given psychotropic medications unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 6 residents (Resident #25) reviewed for psychotropic medications.<br><br>The Psychiatric NP prescribed Resident #25's seroquel for a medical condition the resident did not have.<br><br>This failure could place residents at risk of receiving psychotropic medications unnecessarily.<br><br>Findings included:<br><br>Record review of Resident #25'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 unspecified psychosis. Resident #25 had no diagnosis of Schizoaffective disorder.<br><br>Record review of Resident #25's quarterly MDS, dated [DATE], reflected a BIMS score of 13 indicating he was cognitively intact. His Functional Status assessment indicated he required limited assistance with his ADLs.<br><br>Record review of Resident #25's care plan, dated 10/17/24, reflected he had communication problems related to his stroke, depression related to mental illness, behavioral problems of physical and verbal aggression, and abusive behaviors.<br><br>Record review of Resident #25's physician orders reflected an order from 11/25/24 for seroquel XR Oral Tablet Extended Release 24 Hour 50 MG (Quetiapine Fumarate). Give 1 tablet by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE (F25.1) signed by the NP.<br><br>Resident #25 had been on seroquel since 07/05/12 for unspecified psychosis. On 3/20/23 his seroquel was first prescribed for Schizoaffective disorder.<br><br>Record review of the NP's visit note from 11/25/24 reflected Resident #25's psychiatric history was previously diagnosed vascular dementia, psychosis, and depression. with a plan to continue Seroquel XR. The last Gradual Dose Reduction (GDR) was on 12/07/23.<br><br>Interview on 12/04/24 at 1:19 PM the DON stated Resident #25 had no diagnosis of Schizoaffective disorder, however the resident required seroquel because when he was weaned off it his behaviors became significantly worse. Several GDRs had been attempted unsuccessfully.<br><br>(continued on next page) |

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|---|---|---|---|
| | 455606 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Care Center | 3301 View St<br>Fort Worth, TX 76103 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #25's physician orders on 12/04/23 at 3:15 PM reflected the resident's seroquel had been changed to Seroquel XR Oral Tablet Extended Release 24 Hour 50 MG (Quetiapine Fumarate). Give 1 tablet by mouth at bedtime related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29)<br><br>Review of the facility's Psychotropic Management policy, dated 01/08/21, reflected:<br><br>.1. Residents who have not used antipsychotrophic drugs are not given these drugs unless antipsychotrophic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater. |

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140

Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater, 3 errors of 33 opportunities for errors leading to 6.06% medication error rates, for one of five staff (LVN D) observed for medication pass.

The facility failed to ensure LVN D administered all the crushed medication in the medication cups without leaving residue for Resident #26 and failed to mix prior to administration.

These failures resulted in a 6.06% medication error rate and could put residents at risk who received medications via g-tube for tube occlusion, not receiving the correct dose of medication, and those that took orally not getting intended therapy.

Findings included:

Record review of Resident #26's face sheet, dated 12/05/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE].

Record review of Resident #26's quarterly MDS Assessment, dated 11/24/24, reflected her BIMS was not completed due to resident was rarely/never understood. Her diagnoses included cerebral infarction (stroke), cognitive communication deficit, lack of coordination, hemiplegia (paralysis that affects one side of the body) and hemiparesis (partial paralysis or weakness) following cerebral infarction (stroke) affecting right dominant side, muscle weakness, Vitamin D deficiency, aphasia (language disorder) and gastrostomy status (surgical opening into the stomach). The MDS further revealed Section K -Swallowing/Nutritional Status indicated resident nutritional approaches were feeding tube.

Record review of Resident #26's care plan, revised dated 09/24/24, reflected the following: Focus: Feeding Tube/ nutritional status [Resident #26] requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Feeding tube is related to Dysphagia. [Resident #26] receives diabetasource (1) can 5 times per day with 120ml of water every 6 hours. patient is npo. Goal: Resident will be adequately nourished and remain within 5% of their ideal body weight for the next 90 days. Interventions: Dissolve each med with 5 ml of H2o and administer 10ml of H2o between each med. Administer tube feeding and water flushes as ordered.

Record review of Resident #26's physician orders reflected the following:

-Dissolve each med with 5 ml of H2O and administer 10 ml of H2O between each med. Every shift. Start date 04/28/21 7AM-3PM, 3PM-11PM, 11PM-7AM.

-Enteral Feed Order every shift Flush enteral tube with 30ml water pre/post medication administration and 5-10 ml water between each medication. Start date: 08/14/21 7AM-3PM, 3PM-11PM, 11PM-7AM.

- Vitamin D3 Tablet 125 MCG (5000 UT) (Cholecalciferol) Give 1 tablet via G-Tube in the morning related to Vitamin D Deficiency - Start Date 11/23/21 0900 (9AM)

(continued on next page)

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| NAME OF PROVIDER OR SUPPLIER Park View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3301 View St Fort Worth, TX 76103 | |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Sodium Chloride Tablet 1 GM Give 1 tablet via G-Tube three times a day for hyponatremia (low sodium levels) - Start Date 04/21/23 0900 (9AM), 1400 (2PM), 2000 (8PM)<br><br>-Magnesium Oxide -Mg Supplement Oral Capsule 400 MG (Magnesium Oxide (Mg Supplement)) Give 1<br><br>capsule via G-Tube in the morning for hypomagnesemia - Start Date 09/25/24 0900 (9AM)<br><br>Observation on 12/05/24 at 9:07 AM revealed LVN D prepared the following medication, crushed them and placed them in separate cups:<br><br>-Vitamin D3 tablet 125 mcg<br><br>-Magnesium Oxide - mg supplement 1 capsule 400mg<br><br>- Sodium Chloride 1 tablet 1gm<br><br>LVN D did not dissolve the medication prior to administering to Resident #26. LVN D went to Resident #26's room, positioned the resident, checked for the g-tube placement and residual, and flushed the g-tube with 30 ml of water. LVN D poured the crushed Vitamin D medication, then poured 30ml of water, then poured the crushed magnesium medication and then poured another 30 ml of water. The g-tube clogged due to the medication, LVN D tried to push the medication with a plunger. LVN D was unable to unclog the g-tube, LVN D was observed to empty the water and medication that was in the syringe. She then added another 30ml of water and was able to unclog the g-tube. LVN D proceeded to provide the crushed sodium chloride medication, then poured another 30 ml of water. She then provided the rest of the magnesium medication that she had previously emptied out from the syringe. Two cups were noted to have scanty medication residue remaining in the cups.<br><br>Interview on 12/05/24 at 10:06 AM with LVN D revealed she reviewed Resident #26's physician orders prior to administering her medications and feedings. LVN D reviewed Resident #26's physician order and stated she was not aware that the resident had an order to dissolve crushed medications and to flush 5-10ml of water in between medications. LVN D stated she did not dissolve the resident medication prior to administering and did not flush with the prescribed amount. LVN D stated she was aware medication reside remained in the cups. She stated she was supposed to give all the contents in the cup for Resident #26 to get the full dose of those medications. She stated failure to administer the full doses to Resident #26 would lead to resident having low sodium levels, low Vitamin D or can cause heart issues.<br><br>Interview with 12/05/24 10:14 AM with the DON revealed her expectation was medication administration through g-tube should try to give as much as possible of all the content in the cups. The DON stated when administering medication via g-tube nurses were expected to check the order, crush medication, place them in individual cups, mix with water, and flush in between each medication. She stated failure to administer the full dose leads to resident medications would not be effective. The DON stated it was her responsibility and the ADON to ensure the staffs are doing the right thing and ensure the orders are in place for all residents.<br><br>Record review of the facility's Medication - Treatment Administration and Documentation Guideline policy, revised 04/06/23, reflected the following:<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | To provide a process for accurate, timely administration and documentation of medication and treatments.<br><br>.2. Verify administration accuracy by checking the medication with the EMAR three (3) times.<br><br>.4. Administer the medication according to the physician order |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791<br><br>Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 12 residents (Resident #124) reviewed for equipment safety.<br><br>The facility failed to provide Resident #124 with a bed that had functional wheel locks.<br><br>This failure could place residents at risk of falls due to unsafe equipment.<br><br>Findings included:<br><br>Record review of Resident #124's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting her speech, and muscle weakness.<br><br>Record review of Resident #124's admission MDS, dated [DATE], reflected a BIMS score of 15 indicating she was cognitively intact. Her Functional Status assessment reflected she required extensive assistance with her transfers.<br><br>Record review of Resident #124's care plan, dated 11/26/24, reflected she was a high risk for falls due to right sided weakness.<br><br>Observation and interview on 12/03/24 at 9:43 AM with Resident #124 revealed she had to use a wheelchair due to having a stroke, which caused her right arm and leg to be weak. She stated her bed did not lock, and it made her scared when staff were transferring her. She stated it made her unwilling to try to transfer herself, for fear the bed would roll in the process. Observation of the resident's bed revealed her bed was fitted with wheel locks. All the locks were in the locked position, and the bed rolled with minimal effort. Resident #124 stated the bed did not lock when she was admitted , and she had asked the nursing staff for a new bed but it had not been replaced yet.<br><br>Observation and interview on 12/04/24 at 11:54 AM with Resident #124 revealaed someone, whome she thought was a CNA, had asked her about her bed a few minutes after the surveyor left on 12/03/24. Resident #124 stated around 5:00 PM staff brought a new bed for her that locked.<br><br>Review of the facility's Resident Rights policy, dated 02/20/21, reflected:<br><br>.8. Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment . |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>44937<br><br>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free of roaches for 6 of 15 residents (Residents #56, #62, #99, #106, #114 and #121) reveiwed for pest control.<br><br>The facility failed to ensure the facility was free of roaches.<br><br>This failure could affect residents by placing them at risk for the potential spread of infection, cross-contamination, food-borne illness, and decreased quality of life.<br><br>Findings included:<br><br>Observation and interview on 12/03/24 at 11:34 AM revealed there were roaches along the baseboards in Resident #56 and Resident #99's room, and there were roaches behind Resident #99's dresser. Resident #56 was lying in Bed A, Resident #99 sitting on the side of her bed (Bed B). Resident #56 stated she had concerns with roaches in her room. She and Resident #99 had reported the roaches several times to aides, nursing staff, housekeeping, and to the maintenance department. According to Resident #99, she liked to get ice water in the mornings and have found 4-5 roaches in her cup on several occasions, Resident #99 stated she has tried several things to keep the roaches out of her personal items, but nothing worked. Resident #56 then demonstrated how both residents placed a small plastic cup over their straws and opening to their cups to prevent roaches from getting inside their cups Resident #56 stated she was upset that she reported the roaches but felt like the facility was not coming up with a way to get rid of them.<br><br>Observation and interview on 12/03/24 at 1:30 PM revealed a roach crawling across the resident floor, coming from the restroom across the state surveyor's foot, to the hallway on the south station. According to Residents #106 and #114, they often saw roaches in their room, they were not sure if there was an infestation but have seen roaches during their stay. Observation of a picture on the wall revealed at a minimum 25 baby roaches inside the bottom of a picture frame Resident #106 stated he needed to clean the picture frame; those roaches came while he was in another room on the South Station. The residents stated it would be nice not to have to see roaches crawling around, also stated it was embarrassing to have to deal with having a roach problem.<br><br>In an interview on 12/04/24 at 9:37 AM with the Family Member, she stated she did not have concerns with resident care; however, she did have concerns with pest in the room. The Family Member stated she visited often and has seen roaches on several occasions, Family Member stated it was upsetting to have to leave resident there with roaches, Family Member stated she hoped the facility would figure out a way to get rid of the roach problem.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview and observation on 12/04/24 at 3:53 PM with Housekeeper K observation revealed roaches crawling along the baseboards and corners of the resident room. Housekeeper K stated she had noticed roaches in resident rooms and up and down the hallways. Housekeeper K stated she was responsible to report to her boss she was observed pest in the building, which she had. According to Housekeeper K, she did a deep clean to one room per day to try and keep pests away, Housekeeper K stated having roaches in the building placed residents at risk of not living in a clean home. Housekeeper K stated she did see pest control entering the building; however, she was not sure if it was helping with the pest problem .<br><br>Interview and observation on 12/05/24 at 1:32 PM with Maintenance Assistant H revealed he was aware of a roach problem in the building and noted roaches along the baseboard walls and behind dressers in rooms on the South Station of the building. He stated their pest control vendor was in the facility on 12/04/24. He stated it was the responsibility of everyone to report to the maintenance department when they see pest in the building. He stated if there was an issue with roaches, staff would write their concerns in a book located at the nursing station. He stated the daily procedure was for the maintenance department to check the books at the nursing stations when they arrive for shift. He stated when there were concerns in the book, for example roaches, we would then go and spray, and notify pest control vendor. He stated having a roach problem in the building and in resident rooms could place them at risk of becoming ill or living in unsafe conditions.<br><br>Interview and observation on 12/05/24 at 1:45 PM in revealed the resident was in bed with a food tray at bedside. Resident #62 was observed eating her lunch tray when a roach crawled across her table headed towards Resident #62's plate. Housekeeping in the room, went over to the bedside tray table and killed the roach. Resident #62 stated she did not know there was a roach on her table, that she hoped one had not gotten into her food.<br><br>Interview on 12/05/24 at 1:55 PM with CNA I revealed she worked with residents on the hall and have seen roaches in resident rooms while providing care. CNA I stated she has not received any pest control complaints from residents and had not observed any skin conditions to report. CNA I stated she had reported to the nurse when she saw roaches and has written in the logbook at the nursing station to notify maintenance department. CNA I stated We do have a roach problem in the building. I have seen people spraying, but it was not working. This placed residents at risk of living in unclean environment.<br><br>Interview on 12/05/24 at 2:00 PM with LVN J revealed there was a roach problem. LVN J stated she had seen them all over the hall and in resident rooms. LVN J stated when she saw them, she would contact the maintenance department, and logged it in the book at the nursing station. LVN J stated she has seen the maintenance department on the halls spraying and she had seen the pest control vendor spraying. LVN J stated it was all staff's responsibility to contact maintenance when roaches were seen. LVN J stated having roaches in the building placed residents at risk of being ill and living in unsanitary conditions.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 2/05/24 at 2:12 PM the Maintenance Director revealed the pest control vendor came out weekly to spray the building and resident rooms. The Maintenance Director stated the vendor was in the building on 12/04/24 and he had called them to come out again today. The Maintenance Director stated he knew there was an issue with roaches. He further stated the facility was an old building and you could expect to see some pests. The Maintenance Director stated he knew there were different chemicals used to treat roaches and could ask the vendors to change their chemical product. According to the Maintenance Director, all staff should report to the book at the nursing station, so the maintenance department could address those areas where roaches were seen in the building. The Maintenance Director stated every morning his staff addressed the logbook at the nursing station to begin their day, when they saw roaches in the logbook, they sprayed that room or area, and notified their pest control vendor. The Maintenance Director stated having roaches in the building placed all residents at risk of becoming sick.<br><br>Interview on 12/05/24 at 2:30 PM with the Pest Control Vendor revealed they did address rooms logged in the book. The Pest Control Vendor stated during his walk through in the building he was not able to observe any roaches. The Pest Control Vendor stated he did spray and placed traps throughout the hall. The Pest Control Vendor stated if there was an empty room he sprayed and bated the room, if the room was occupied, he batted them pretty well.<br><br>Interview on 12/05/24 at 2:30 PM with the Administrator revealed they have a pest control vendor entering the facility weekly. The Administrator stated he has observed them spraying on the one hundred hallways. According to the Administrator, he expected all staff to follow chain of command and communicate with him when there was a problem with pests. The Administrator stated he hated the facility had roaches and did not want that for the residents because it placed them at risk for an overall decline in quality of life .<br><br>Review of the facility's Pest Control Program policy, dated 01/10/20, reflected:<br><br>It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.<br><br>Facility will ensure that appropriate chemicals are used to control pests but can be used safely inside the building without compromising resident health.<br><br>Facility will obtain services as indicated related to issue that may arise in between as scheduled visits with the outside pest service and treat as indicated . |