

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

Printed: 07/18/2026
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 02/12/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents had the right to a safe, clean, comfortable and homelike environment to include housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 3 of 32 residents (Residents #95, #86 and #14) and 1 of 3 shower rooms (Shower room [ROOM NUMBER]) reviewed for environmental conditions.1. The facility failed to ensure the privacy curtains for Residents #95, #86 and #14 were maintained in a clean and sanitary manner free of dried brown substances.2. The facility failed to ensure the walls in Shower room [ROOM NUMBER] were properly maintained and free of cracked and missing tiles. These failures could place residents at risk of living in an unsanitary, unsafe environment and a diminished quality of life. 1. Observation and interview on 02/10/26 at 10:55 AM of Resident #95's room revealed the privacy curtain had several dried brown substances on it. Resident #95 stated housekeeping cleaned her room; however, she could not recall the last time her privacy curtain was cleaned. Observation and interview on 02/10/26 at 11:28 AM of Resident #86's room revealed the privacy curtain had several dried brown substances on it. Resident #86 stated his room got cleaned but was not sure who cleaned the privacy curtains. Observation and interview on 02/10/26 at 1:30 PM of Resident #14's room revealed the privacy curtain had several dried brown substances on it. Resident #14 stated housekeeping cleaned her room; however, she could not recall the last time her privacy curtain was cleaned. Interview on 02/12/26 at 2:58 PM, Housekeeping R revealed if a privacy curtain needed to be changed or washed, she writes it down on a work log and provides it to Environmental Service Manager. She stated she had not had any resident complaint about privacy curtains being dirty. She stated she had observed privacy curtains with stains and would notify the Environmental Service Manger about it. Housekeeping R stated she was not aware of how often privacy curtains were washed. She stated everyone was responsible for reporting any dirty privacy curtains. She stated it was a biohazard for residents to have dirty privacy curtains. Interview on 02/12/26 at 3:14 PM, the Environmental Service Manager revealed everyone was responsible for notifying him when a privacy curtain needed to be washed. He stated most of the privacy curtains were stained and he had talked to the Administrator about a month ago about replacing the privacy curtains. He stated the privacy curtains were ordered; however, they were on back order. Environmental Service Manager stated he did not have any work-log pertaining to privacy curtains or keep a list of privacy curtains that needed to be washed. He stated the potential risk of not washing or removing stained privacy curtains would be germs/sanitation. Interview on 02/12/26 at 4:33 PM, the Administrator revealed housekeeping was responsible for removing and washing privacy curtains. She stated she had noticed several privacy curtains to be stained. She stated she had ordered new privacy curtains; however, they were in back order. She stated the privacy curtains were ordered either December 2025 or January 2026. She stated in the meantime her expectations were for housekeeping to continue to wash the privacy curtains. She stated it was unsanitary for the residents if privacy curtains were not cleaned. 2. Observation and interview on 02/12/26 at 12:09 PM in Shower room [ROOM NUMBER] revealed there were cracked wall tiles on a corner near the floor and 5 (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing wall tiles where the wall met the floor. The Maintenance Director stated he had fixed those a few months ago and was not aware they were broken. He stated it was not homelike, and water could get into the wall if the tiles were not replaced. The Maintenance Director said his expectation was for staff to tell him of any repairs needed. He said he made environmental rounds and started with the most critical and fixed those before moving on to the next project. Interview on 02/12/26 at 3:50 PM, the DON stated she expected staff to let maintenance know if repairs were needed. She stated it would not be homelike, and residents could be at risk of injury or infections. Interview on 02/12/2026 at 4:38 PM, the Administrator stated she expected staff to report to Maintenance if repairs were needed. She stated the risk to residents could be mold, injury and it not being homelike. Record review of the facility's Resident Rights policy, dated 02/20/21 reflected that: .8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal care for 4 of 32 residents (Residents #12, #27, #81, and #86) reviewed for ADL care. The facility failed to ensure nail care, to include trimming and cleaning, was provided to Residents #12, #27, #81, and #86. The failure placed the residents at risk of hygiene and safety risks such as nail tearing, injury, and functional difficulties. Findings included: Record review of Resident #12's admission Record, dated 02/12/2026, revealed a [AGE] year-old female with original admission date of 07/02/2025 with a diagnosis of hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side. Record review of Resident #12's admission MDS, dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #12's care plan, dated 07/02/2025 and revised on 11/16/2025, revealed Resident #12 had an ADL Self-care Performance Deficit and was at risk of not having their needs met in a timely manner. Resident #12's performance deficit was related to CVA (stroke) w/L hemiplegia. Interventions included ADL assistance as required, and Resident #12 was dependent for ADLs. Observation on 02/10/2026 at 10:47 AM revealed Resident #12's left hand was in a splint. Observation and interview on 02/12/2026 at 12:38 PM revealed Resident #12's nails on both hands were long, approximately between 1/4 to 1/2 an inch. She stated she wanted them cut. Record review of Resident #27's admission Record, dated 02/12/2026, revealed a [AGE] year-old male with an original admission date of 10/17/2025. Resident #27's diagnoses included unspecified dementia (memory loss and cognitive decline without a specific cause), Type 2 Diabetes (a disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels) and Spina Bifida (a condition when the spine and spinal cord do not close properly in early pregnancy). Record review of Resident #27's Quarterly MDS, dated [DATE], revealed a BIMS score of 13, indicating intact cognition. Record review of Resident #27's care plan, dated 10/17/25 and revised on 01/15/2026, revealed Resident #27 had an ADL Self Care Performance Deficit and was at risk of not having their needs met in a timely manner. Resident #27's performance deficit was related to Spina bifida. Interventions included ADL assistance as required. Bathing: total assist, provide shower, shave, oral care, hair care and nail care per schedule and when needed. Observation and interview on 02/10/2026 at 10:56 AM revealed Resident #27's nails on his left hand appeared clean except for the thumb nail, and his right hand had a black and brown substance underneath all nails. The nails measured approximately 1/8 to 1/4 inch past the nail bed. Resident #27 stated he wanted his nails cut. Observation and interview on 02/12/2026 at 12:43 PM revealed in Resident #27's room, CNA N stated Resident #27's nails were long and she noticed the dirt underneath. She stated CNAs did not cut nails unless the nurse asked them to. She stated residents could scratch themselves and could be at risk of infections if nails were not trimmed and clean. Interview on 02/12/2026 at 1:07 PM revealed RN O stated nurses and CNAs do nail care, however if the resident was diabetic, they preferred CNAs not. She stated nail care was not scheduled but done as needed. RN O said if not done there could be injuries, residents could scratch themselves or a risk of infection. Record review of Resident #81's Face Sheet, dated 02/11/26, reflected a [AGE] year-old male who admitted to the facility on [DATE], and readmitted on [DATE]. Record review of Resident #81's Quarterly MDS, dated [DATE], reflected the resident had diagnoses that included: Cerebral Infarction with hemiplegia (Stroke resulting in paralysis of one side of body), lack of coordination, need for assistance with personal care, muscle weakness, Diabetes Mellitus (chronic condition in which the body does not regulate blood sugar levels), Dementia (decline in memory and thinking skills), and Hypertension (high blood pressure). The MDS reflected Resident #81 had a BIMS score of 11, indicating moderate cognitive impairment. The MDS also reflected Resident #81 was frequently incontinent of bowel and bladder. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #81's Care Plan, revised 01/15/26, revealed the resident had an ADL self-care performance deficit with interventions to provide shower, oral care, and nail care per schedule and when needed. The Care Plan also revealed the resident had a diagnosis of diabetes with interventions to monitor skin for redness and infection, and the resident was noted to have fragile skin and was at risk for skin tears with an intervention to keep skin clean, dry, and to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against sharp or hard surfaces. Record review of Resident #81's Order summary report, dated 02/12/26 revealed the following orders: May be seen for evaluation and treatment of mycotic nail care and debridement (treatment of a fungal nail infection where the thick, damaged, or infected nail is removed). may consult podiatrist. Record review revealed no physician orders for fingernail care. Record review of Resident #81's progress notes revealed no documentation of refusal of fingernail care. Observation and interview on 02/10/26 at 10:09 AM revealed Resident #81 had long fingernails on both his hands, ranging approximately 1/4 - 1/2 inch long with rough edges and dark debris underneath. Resident #81 stated he did not like his fingernails long and wanted them shorter. He stated he did not remember when they were last cut. Observation and interview on 02/11/26 at 12:16 PM revealed Resident #81 lying in bed. Resident #81 stated he got a shower yesterday and did not receive nail care. Observation of both hands revealed all fingernails approximately 1/4 - 1/2 long with jagged sharp edges. Resident #81 stated he was still wanting his fingernails cut. Observation and interview on 02/12/26 at 10:41 AM revealed Resident #81's fingernails were long and there was a brown substance underneath them. Also, the edges of his nails were rough and uneven. Resident #81 stated he had told the nursing team he wanted them cut. Interview and observation on 02/12/26 at 11:40 AM with CNA D revealed she regularly worked with Resident #81. CNA D stated Resident #81 received daily showers and she had showered him on 02/11/26. During the interview, CNA D entered Resident #81's room and stated his nails were long and jagged. Resident #81 stated he wanted his nails cut. After leaving resident's room, CNA D stated she had not offered to cut his nails because she assumed he would tell her when he wanted them cut. CNA D stated she had not noticed his long nails. She stated Resident #81 had not refused nail care. CNA D stated it was her and the nurse's responsibility to ensure Resident #81's nails were cut. CNA D stated the nurse would cut Resident #81's nails since he was a diabetic. CNA D stated the risk of having long fingernails was they could scratch themselves or another resident. Interview on 02/12/26 at 1:02 PM with LVN E revealed she worked regularly with Resident #81. She stated the last time she checked Resident #81's fingernails was two weeks ago, and she did not notice them long. LVN E stated she was unsure who cut Resident #81's fingernails last. LVN E stated most of the time Resident #81 was sleeping and she did not want to bother him. LVN E stated she had observed Resident #81's fingernails and they were long. LVN E stated she was responsible for cutting Resident #81's nails. LVN E stated the risk of having long fingernails was an infection risk and residents could cut themselves. Interview on 02/12/26 at 1:43 PM with ADON F revealed she expected her staff to do nail care during all showers. ADON F stated she had not been aware of Resident #81 refusing any nail trims and there would be documentation if he had. ADON F stated she had not seen Resident #81 with long fingernails. She stated it was all staff's responsibility to ensure nail care was completed. ADON F stated the CNAs could notify the nurse. ADON F stated the nurses cut any diabetic nails. ADON F stated the risk of not performing nail care/trims was the resident could cut themselves, get debris underneath, and lead to infection control issues. Record review of Resident #86's annual MDS assessment, dated 11/24/25, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted [DATE]. Resident #86's diagnoses included cerebrovascular accident (loss of blood flow to part of the brain), encephalopathy (disturbance of brain function), contracture (a permanent tightening of the muscles), cognitive communication deficit, and muscle wasting and atrophy (loss of muscle tissue). Resident #86's BIMS score was 14 which indicated his cognition was intact. The MDS Section GG - Functional Abilities indicated the resident was dependent on 2 or more helpers to assist with personal hygiene. Record (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #86's Care Plan, revised 07/17/25, reflected Focus: ADLs: [Resident #86] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Performance deficit is related to: left side hemiplegia/hemiparesis/contracture. Goal: Resident will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Observation and interview on 02/10/26 at 11:28 AM revealed Resident #86 was in his room lying in bed. Observed Resident #86's left hand to be contracted and thumb fingernail to be half an inch long and curling to the side. Resident #86 stated his right-hand fingernails were cut but not his left-hand fingernails. Resident #86 was unable to open his left hand but stated his other fingernails were long. Resident #86 stated he wanted his fingernails to be cut short. Observed CNA P entered the room and assisted with opening Resident #86's hand. Observed Resident #86's middle finger and ring finger nails to be 1/4 - 1/2 long. No open areas were noted. Interview on 02/12/26 at 1:28 PM, CNA P revealed she was the CNA assigned to Resident #86. She stated Resident #86 had long fingernails on his contracted hand. She stated she was not sure if Resident #86 refused contracted hand fingernails to be trimmed. CNA P stated the nurses were responsible for trimming resident's fingernails. Interview on 02/12/26 at 1:52 PM, RN Q revealed she was the nurse assigned to Resident #86. She stated she had seen Resident #86's contracted hand fingernails to be long. She stated Resident #86 was not a diabetic resident and his nails should be trimmed by either the CNAs or nurse. She stated that depending on the resident's mood, Resident #86 would allow them to cut his fingernails. RN Q stated the potential risk of having long nails while the hand was contracted could lead to fingernails digging into his hand and cause infection. Interview on 02/12/26 at 3:50 PM with the DON revealed all nursing staff were responsible for nail trims. The DON stated she was not aware if Resident #12, Resident #27, Resident #81, or Resident #86 were residents who refused nail trims. The DON stated she expected the nurses to keep nails trimmed and document any refusals. The DON stated the risk of having uncut fingernails was hurting themselves and skin integrity issues. Record review of facility Nail Care policy, revised 1/1/2025, reflected the following: Purpose: To provide for personal hygiene needs and prevent infection. NOTE: Precaution should be used when trimming nails of a resident with diabetes and should be done by a Licensed Nurse or Physician. Record review of the facility's policy, titled Activities of Daily Living, revised 1/1/2024 revealed the following: It is the policy of this home to assure residents have their activities of daily living met.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 5 residents (Resident #86) reviewed for restorative care. The facility failed to obtain a physician order and care plan for the use of a splint for Resident #86's left hand contracture (a permanent tightening of the muscles). This failure could place residents at risk of increased contractures, not receiving care and services to maintain their highest level of well-being and decline. Findings include: Findings include: Record review of Resident #86's annual MDS assessment, dated 11/24/25, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted [DATE]. Resident #86's diagnoses included cerebrovascular accident (loss of blood flow to part of the brain), encephalopathy (disturbance of brain function), contracture (a permanent tightening of the muscles), cognitive communication deficit, and muscle wasting and atrophy (loss of muscle tissue). Resident #86's BIMS score was 14 which indicated his cognition was intact. The MDS Section GG - Functional Abilities indicated functional limitation in range of motion upper extremity (shoulder, elbow, wrist, hand). The MDS Section O - Special Treatments, Procedures, and Programs indicated no use of a splint or brace assistance. Record review of Resident #86's Care Plan, revised 07/17/25, reflected Focus: ADLs: [Resident #86] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Performance deficit is related to: left side hemiplegia (paralysis)/hemiparesis (weakness)/contracture. Goal: Resident will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. The care plan did not address the use of a splint. Record review of Resident #86's physician orders revealed no orders for the use of a splint. Observation and interview on 02/10/26 at 11:28 AM revealed Resident #86 in bed. Observed Resident #86's left hand to be contracted, and resident did not have a splint on. Resident #86 stated at some point he was using a splint for his left hand but then for a while staff stopped putting it on. Resident #86 stated he could not recall the last time he had a splint on. Observations on 02/10/26 from 1:20 PM through 4:30 PM revealed Resident #86 had a splint on his left hand. Observation on 02/11/26 at 12:15 PM revealed Resident #86 was observed in the dining room, and he had a splint on his left hand. Observation on 02/12/26 at 11:14 AM revealed Resident #86 to be in the dining room. Resident #86 did not have a splint on his left hand. Observation on 02/12/26 at 1:21 PM revealed Resident #86 had a splint on his left hand. Interview on 02/12/26 at 1:28 PM, CNA P revealed she was the CNA assigned to Resident #86. She stated Resident #86's left hand was contracted and required the use of a splint. CNA P stated the nurses apply the splint on Resident #86. She stated the splint is put on every day when the resident allowed them to put it on. Interview on 02/12/26 at 1:40 PM, RN Q revealed she was the nurse assigned to Resident #86. She stated Resident #86 had a contracted left hand and required the use of a splint. RN Q stated whoever gets the resident up and ready for the day was responsible for putting on the splint. She stated she was the one who applied the splint on Resident #86 today (02/12/26). RN Q stated a physician order was needed for the use of a splint. She stated she was aware Resident #86 had no physician order for the splint; however, she still applied it because she knew he used it. RN Q stated there was no potential risk for putting the splint on without a physician order; however, for any treatment provided to a resident a physician order needed to be obtained first. RN Q stated contractures, and any use of a device should be care planned. RN Q reviewed Resident #86's care plan and stated resident's left-hand contracture and the use of the splint was not care planned. She stated each department was responsible for care plans, and the clinical team went over the care plans during morning meetings. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN Q stated the potential risk of not care planning the use of the splint would be staff not knowing the correct treatment to provide to the resident. Interview on 02/12/26 at 3:37 PM, ADON H revealed she was the ADON assigned to Resident #86. She stated Resident #86's left hand was contracted. She stated therapy would usually put on a splint on him, but resident was not compliant with it. ADON H stated she had not seen Resident #86 with a splint on. She stated she was not aware nursing staff were applying the splint on Resident #86. She stated she was not aware Resident #86 did not have a physician order for the splint. She stated before starting any treatment, nurses needed to make sure a physician order was obtained. ADON H stated the potential risk of not having a physician order for the use of a splint would be staff not knowing when to put on and take off the splint. She stated the therapy department was responsible for providing an order for the use of a splint. ADON H stated contractures, and the use of any device should be care planned. ADON H stated she was not aware Resident #86 was not care planned for the use of the splint. She stated each department was responsible for the care plan. She stated therapy department was responsible for contractures. ADON H stated the potential risk of not care planning the use of splint/devices would be staff not able to follow up or monitor treatment. Interview on 02/12/26 at 3:54 PM the DON revealed Resident #86 did not require the use of a splint. She stated she had never been told Resident #86 needed a splint. The DON stated she was not aware her staff were putting a splint on Resident #86's left hand. She stated the expectation was for therapy to evaluate, assess the resident for any contractures and obtain an order. The DON stated once the resident was assessed, then therapy must educate the staff on how to put on and remove the splint. She stated her expectations were for nurses to obtain a physician order before putting on the splint. The DON stated the potential risk of putting on a splint without a physician order would be skin integrity. The DON stated contractures needed to be care planned, and she stated she was not aware it was not. She stated therapy was responsible for care planning contractures and the use of a splint. The DON stated the potential risk of not care planning contractures or the use of a splint would be staff not able to monitor. Interview on 02/12/26 at 4:03 PM, Occupational Therapy revealed she had not worked with Resident #86 in a while. She stated on Tuesday 02/10/26 the staff assigned to Resident #86 came into the therapy room looking for a splint. She stated staff were notified that Resident #86 had a splint in his room, which was located. Occupational Therapy stated that since Resident #86 was not receiving any therapy from them it was the responsibility of the nurses to put on the splint. She stated the Occupational Therapist that provided Resident #86 services was on leave and she was not sure of what recommendations were given for the use of the splint. Occupational Therapy stated Resident #86 had a paper order for the use of the splint and it was provided to ADON H and had ADON H signed the form showing that it was provided to her. She stated from what she recalled nurses were trained in how to put on and remove the splint on Resident #86. Occupational Therapy stated they no longer had the original paper order for the use of the splint. She stated the MDS Coordinators were responsible for care plans. Interview on 02/12/26 at 4:12 PM, the MDS Coordinator revealed each department was responsible for care planning each service provided to a resident. She stated contractures should be care planned and therapy was responsible for care planning contractures or the use of any device. Follow up interview on 02/12/26 at 4:20 PM, ADON H revealed she was never provided with a paper order from therapy. Interview on 02/12/26 at 4:35 PM, the Administrator revealed nurses were responsible for obtaining physician orders for the use of a splint. She stated the expectation was for therapy to not put any equipment on a resident without being evaluated and assessed first. If the resident was appropriate for the use of a splint, then therapy should train all nurses on the use of the equipment. The Administrator stated therapy had not provided any physician form to the nursing staff and was she not aware Resident #86 required the use of a splint. She stated there was a potential risk of not having a physician order for the use of a splint; however, she did not know exactly. Record review of facility Contracture Management policy, dated 2/1/25, reflected the following: Policy: The purpose of this Contracture Management Policy is to provide a framework for preventing, identifying, and (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	managing contractures in long-term care residents. This policy outlines the responsibilities of caregivers, the procedures for assessment and intervention, and the documentation requirements. Interdisciplinary Notes: Ensure that interdisciplinary notes from nurses, therapists, and physicians are included in the resident's medical record, reflecting the collaborative approach to contracture management.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 resident (Resident #72) reviewed for dialysis documentation. The facility failed to ensure nurses documented ongoing assessments of Resident #72's condition and monitoring complications before and after dialysis treatments. This deficient practice could place residents at risk of complications from dialysis due to the lack of documentation between the facility and dialysis center in the event of a medical event. Findings include: Record review of Resident #72's face sheet, dated 02/12/2026, revealed resident was a [AGE] year-old male admitted to the facility on [DATE] with a readmission on [DATE]. Resident #72's admitting diagnoses included End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids); Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (is a common, progressive nerve damage condition causing pain, burning, tingling, or numbness typically starting in the feet and hands); Dependence on Renal Dialysis (patients who require dialysis treatment for chronic kidney disease or acute kidney injury). Record review of Resident #72's quarterly MDS, dated [DATE], revealed his BIMS Score was 15, which indicated the resident's memory intact. Resident #72's cognitive abilities were within a normal range. Resident #72 could make independent decisions regarding her care. Record review of care plan undated, revealed in part Resident #72 needed hemodialysis r/t renal failure every Monday, Wednesday, and Friday. Resident #72 would have no complications from dialysis through the review date. Monitor dialysis dressing and change as ordered; Report abnormal bleeding to physician. Monitor for possible complications such as shortness of breath, peripheral edema, chest, pain, elevated blood pressure, dry itchy skin, nausea and vomiting, or bleeding at access site. Record review of Resident #72's Dialysis Communication Forms revealed, dates 05/07/2025 and 02/09/2026, were fully completed from 2 dialysis treatments. Dialysis Communication Forms revealed dates 10/27/2025, 11/03/2025, 11/05/2025, 11/07/2025, 11/10/2025, 12/15/2025, 01/03/2026, 01/28/2026, 02/02/2026, and 02/06/2026 were not fully completed with missing documentation. Resident #72 did not complain about any complications from missing documentation. No complications noted in resident's file. Interview on 02/12/2026 at 4:15 PM, the DON revealed the completed Dialysis Communication Records were to be completed and kept in a binder for each dialysis resident. The DON said the ADONs monitor these forms, she said her expectation is to have the charge nurse contact the Dialysis Center and request the Dialysis Communication Record if not returned with the resident. The charge nurse was supposed to complete the form and send with resident to the dialysis center. The risk of not having the completed form for the dialysis resident is potentially an order can be missed or a change that may have occurred at dialysis center was not communicated back to facility. Charge nurses are to check resident's vitals before resident leave for dialysis and upon the resident's return. The DON stated training would be provided to all nurses r/t the Dialysis Communication Records. In an interview on 02/12/2026 at 4:39 PM, the Administrator revealed her expectations are for charge nurses to complete the Dialysis Communication Record, send with resident to dialysis, review form upon resident's return from dialysis. Forms are to be kept in a notebook for resident at nurse's station. Record review of the facility's policy Dialysis - General Guidelines and Management revised 01/01/2024 revealed in part, It is the policy of this home that dialysis residents will receive dialysis service as per physician orders and will be monitored accordingly. Prior to dialysis treatments, assess vitals, edema, access site, mental status, complaints of pain/discomfort, blood sugar (if ordered) and administer meds as directed by the dialysis center.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interviews and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure the dishwasher's chemical concentration and temperatures were logged. These failures could place residents at risk of foodborne illness. Findings included: Observation and interview on 02/12/26 at 8:59 AM, Dietary Staff M ran a cycle of the dishwasher and used a test strip to check the chemical sanitizer. She stated she checked the temperature and chemicals once a day before washing dishes. The test strip was dark purple and read 100 parts per million and was within the correct concentration of 50 to 100 parts per million. Record review of facility's Low-Temperature Dish machine Sanitizer Log for February 2026, revealed no water temperature or chemical concentration checks for the following dates:- 02/03/26 - evening- 02/04/26 - midday and evening- 02/05/26 - midday and evening- 02/06/26 - midday and evening- 02/07/26 - morning, midday and evening- 02/08/26 - morning, midday and evening- 02/09/26 - midday and evening. Interview on 02/12/26 at 9:58 AM, the Dietary Manager stated staff were supposed to check the dishwasher 3 times a day and record it on the log to disinfect and make sure dishes were clean. She stated she or the Assistant Manager would train staff on that procedure. The Dietary Manager stated she checked the dishwasher in the morning herself, and the Assistant Manager ran it at night. When asked about the blanks on the log, she stated she did not see the log and there were 2 days when the dishwasher was down. She said they did not use the log when it was down. Interview on 02/12/26 at 11:57 AM, the Maintenance Director stated the dishwasher was out of service last week. He said kitchen staff noticed it was not working, and he was able to fix it the same day. He said he purchased some drain covers to collect food and to keep silverware from getting in there. The Maintenance Director said it was important to ensure the dishwasher was working so dishes would get properly cleaned and sanitized and to prevent food borne illness. Interview on 02/12/2026 at 4:38 PM, the Administrator stated she expected kitchen staff to report to the Maintenance Director and herself if major repairs were needed including the freezer, stove, or dishwasher. She stated if the dishwasher was not working or chemicals were not being checked there was potential for unsanitary dishes. Record review of Maintenance Work Order Logs, from November 2025 to February 2026 did not have dishwasher listed. Record review of the facility policy titled Ware Washing dated 7/2022 revealed the following: The purpose of ware washing is to clean and sanitize utensils and equipment used during the preparation and service of food from the dietary department. Proper ware washing is an essential component in the prevention of food borne illnesses. Procedure.3. Dish Machine temperatures (wash and rinse) will be observed and recorded on the Dish Machine Temperature Log before starting the ware washing process after each meal. For low temperature machines the chemical sanitizer strength will be tested and recorded as well.2. Low temperature Dish Machines.b. chemical: Chlorine Sanitizer = 50-100 ppm (parts per million).		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to dispose of garbage and refuse properly for 3 of 3 dumpsters. (Dumpsters #1, #2, and #3)1. The facility failed to ensure the doors were completely shut on dumpster #1 2. The facility failed to ensure the lids were closed on dumpsters #1 and #3.3. The facility failed to ensure used incontinent briefs and other garbage were not on the ground surrounding the dumpsters. These failures could place residents at risk of an unsanitary environment and could attract pests, rodents and other animals. Findings included:Observation of the dumpster area on 02/10/2026 at 9:12 AM, revealed the following:- both doors were open on dumpster #1 exposing trash, - Used incontinent briefs, and a clear trash bag with soiled incontinent briefs was lying on the ground next to dumpster #1,- Dumpsters #1 and #3's lids were not closed. Interview on 02/12/2026 at 9:58 AM, the Dietary Manager stated kitchen and environmental services staff were responsible for taking trash outside. She stated the dumpster doors were supposed to be closed, and the area should be clean. She stated if not, it could look bad, be unsanitary and could bring pests. Interview on 02/12/2026 at 3:08 PM, the Environmental Services Manager stated floor techs were responsible for taking trash to the dumpsters. He stated the doors should be closed and trash picked up. He stated if not, it could bring pests and trash could fly around. Interview on 02/12/2026 at 4:38 PM, the Administrator stated floor techs were responsible for taking trash outside and for the surrounding area. She said the dumpster doors should be closed all the way and trash should be picked up and if not it could bring rodents .The facility did not provide a policy on garbage and refuse disposal.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain safe and functional essential kitchen equipment in the facility's only kitchen. The facility failed to ensure the seal on the walk-in freezer door was replaced properly. These failures could place residents at risk of not having essential equipment maintained and in working order. Findings included: Observation on 02/10/2026 at 8:55 AM, revealed ice buildup was accumulated along the door frame, threshold, and floor of the walk-in freezer. Interview on 02/12/2026 at 9:58 AM, the Dietary Manager stated Maintenance was responsible for ensuring the freezer was clean. She stated she noticed the ice buildup 3 months ago and someone put a new seal, but it was not done properly. She said the risk was someone could trip and fall. The Dietary Manager said kitchen staff had a communication book for repairs and the Maintenance Director would come to check. Observation on 02/12/2026 at 10:13 AM, revealed ice buildup was still accumulated along the door frame and threshold of the walk-in freezer. Interview on 02/12/2026 at 11:57 AM, the Maintenance Director said the freezer was functioning properly and the seal had been replaced in November. He said it was important to ensure the freezer was working to protect food and prevent illness and the ice could be a hazard to employees. Interview on 02/12/2026 at 4:38 PM, the Administrator stated she expected kitchen staff to report to the Maintenance Director and herself if major repairs were needed including the freezer, stove, or dishwasher. She stated if the freezer was not working it could affect the quality of the food if the temperature got out of range. Record review of Maintenance Work Order Log, dated November 2020, reflected that the seal around the freezer was resolved on 11/20/25. Record review of the U.S. FDA Food Code 2022 revealed, .4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 11 residents (Resident #14) reviewed for enteral feeding. The facility failed to follow physician's orders of providing Resident #14 with her 16 hours of her enteral feeding intake from 02/10/26 to 02/11/26. This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care. Findings included: Record review of Resident #14's quarterly MDS assessment, dated 12/13/25, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted [DATE]. Resident #14's diagnoses included gastrostomy status (surgical opening (stoma) in the stomach), dysphagia (difficult swallowing) following cerebral infarction (stroke), malnutrition (lack of proper nutrition). Resident #14's BIMS score was 13 which indicated her cognition was intact. The MDS Section K - Swallowing/Nutritional Status indicated the resident's nutritional approach was a feeding tube and mechanically altered diet. Record review of Resident #14's care plan revised date 01/22/26 reflected: Focus: Feeding Tube: [Resident #14] requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Feeding tube is related to: Dysphagia. Goal: [Resident #14] will maintain adequate nutritional and hydration status as evidenced by weight being stable, no signs or symptoms of malnutrition, or dehydration through review date. Intervention: Administer tube feeding and water flushes as ordered. Monitor/document/report to the physician as needed for the following potential complications related to tube feedings: Fever, shortness of breath, abnormal breath/lung sounds, tube dislodged, signs/symptoms infection at site, tube malfunction, abdominal pain distension or tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, and signs and symptoms of dehydration. Record review of Resident #14's physician orders reflected: Enteral Feed Order every 24 hours for ENTERAL FEED - ARTIFICIAL NUTRITION Jevity 1.5 cal for Enteral feed Continuous overnight feeds at 60 ml/hr x 16 hours 6pm-10am w/ 300 cc H2O flush q 4 hours Start Date 02/09/2026. Record review of Resident #14's February 2026 MAR revealed Enteral Feed Order every 24 hours for ENTERAL FEED - ARTIFICIAL NUTRITION Jevity 1.5 cal for Enteral feed Continuous overnight feeds at 60 ml/hr x 16 hours 6pm-10am w/ 300 cc H2O flush q 4 hours -Start Date- 02/09/2026 1800 (6:00PM) revealed it was started on 02/10/25 at 1804 (6:04 PM) Observation and interview on 02/10/26 at 1:30 PM, Resident #14 was observed in her room lying in bed. Resident #14 stated she had a g-tube and she received her g-tube feedings at nights. Observed g-tube machine next to resident's bed, and g-tube was not on. Observation on 02/11/26 at 8:20 AM, revealed Resident #14 was sleeping. Observed formula bag to be dated 02/10/26. Resident #14's g-tube machine was turned off. Observation on 02/11/26 at 9:48 AM, revealed Resident #14 was sleeping. Resident #14's g-tube machine was turned off. Interview on 02/11/26 at 9:50 AM, RN G revealed she was the nurse assigned to Resident #14. She stated Resident #14 had a g-tube and received her feeding at night for 16 hours and to be disconnected at 8AM the following day. RN G stated she disconnected Resident #14 at 8:00 AM. She stated she reviewed Resident #14's physician orders before disconnecting her. Observed RN G reviewing Resident #14's physician orders and stated she was not aware that the physician orders had been changed on 02/09/26. She stated Resident #14 should have been disconnected at 10:00 AM instead of 8:00 AM. RN G stated she failed to follow physician orders. She stated there was no risk to the resident if she was disconnected from her feeding two hours prior to the ordered disconnection time. Interview on 02/12/26 at 10:04 AM, ADON H revealed she was the ADON assigned to Resident #14. She stated her expectations were for the nurses to always review physician orders prior to administering anything to a resident and not depend on the next person to notify them. She stated if a nurse needs clarification on an order they are expected to contact the (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor. ADON H stated RN G informed her about disconnecting Resident #14 two hours early. She stated each nurse was responsible for reviewing physician orders and it was her responsibility to ensure physician orders were being followed. ADON H stated the potential risk of not providing the correct feeding time could lead to malnutrition. Interview on 02/12/26 at 3:50 PM, the DON revealed she expected her nurses to follow the physician orders, provide the correct quantity and feeding time. She stated nurses should review the physician orders before disconnecting the resident from her feedings. She stated the nurses were responsible for putting in physician orders in the system and the ADONs were responsible for ensuring physician orders were being followed. The DON stated potential risk of not providing the correct feeding time could lead the resident to not get her calorie intake. Record review of facility Feeding Tube Administration, Nutrition and Care policy, revised 12/2012, reflected the following: Enteral feedings will be administered per physician order. Complications related to enteral feedings will be minimized through provision of proper care. Resident's receiving enteral feedings will receive adequate nutrition and fluid to meet their individual needs, to the extent possible in consideration of their clinical condition and wishes.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 2 medication rooms (North medication room) reviewed for pharmacy services. The facility failed to remove expired Bisacodyl suppositories, with an expiration date of 01/21/26 and Acetaminophen suppositories, with an expiration date of 01/09/26, from the North medication room refrigerator. This failure could place residents at risk of receiving medications that were ineffective. Findings included: Observation on 02/11/26 at 3:10 PM of the North medication room refrigerator with LVN A revealed four 10mg Bisacodyl suppositories (medication administered rectally to treat constipation) with an expiration date of 01/21/26, and 11- 650mg Acetaminophen suppositories (medication administered rectally for pain and fever reduction) with an expiration date of 01/09/26. Interview on 02/11/26 at 3:16 PM, LVN A stated the Bisacodyl suppositories expired on 01/21/26 and the Acetaminophen suppositories expired on 01/09/26. LVN A stated the managers oversaw and checked the medication room for expired medications, but she stated it was all nurses' responsibility to ensure there were no expired medications in the storage rooms. LVN A stated she checked the medication expiration date prior to administering any medications but did not routinely inspect the medication rooms for expired medications. LVN A stated by failing to remove expired medications, the medications could be administered, and the dose could be ineffective or cause an adverse reaction. Interview on 02/12/26 at 12:44 PM, ADON B revealed she expected the nurses to be reviewing and checking the medication room daily for expired medications. ADON B stated it was her and the nurse's responsibility to ensure all expired medications were removed. ADON B stated she checked the medication room most mornings for expired medications, and had checked it this week, but must have missed the expiration date on the suppositories. ADON B stated the risk of having expired medications was that they could be administered to residents and not function properly. Interview on 02/12/26 at 4:03 PM, the DON revealed she expected the nurses to check the medication rooms daily for expired medications. The DON also stated the ADONs were expected to conduct rounds of the medication rooms at least weekly to ensure there were no expired medications. The DON stated it was all nursing staff's responsibility to ensure there were no expired medications. The DON stated that no specific training on auditing the storage room for expired medications had been completed with the floor nurses since she started; however, nurses were expected to review the storage room for expired medications when retrieving medications and supplies. The DON stated the risk of having expired medications was that the medications could be administered and not be effective or have adverse effects. Record review of the facility's Medication Storage policy, dated 01/20/21 reflected the following: .8. Medication Carts are routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are removed and destroyed in accordance with the facility policy. 9. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with the facility policy.		

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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** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, 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 4 residents (Resident #45) reviewed for infection control practices. The facility failed to ensure CNA C performed hand hygiene prior to and during incontinence care for Resident #45. These failures could place residents at risk of cross-contamination and infections. Findings included: Record review of Resident #45's Face Sheet, dated 02/12/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #45's admission MDS, dated [DATE], reflected the resident's diagnoses included: Cerebral infarction (stroke caused by a blocked blood vessel in the brain), Degenerative disease of nervous system (disease that causes the brain or nerves to slowly break down over time), Hemiplegia (Paralysis on one side of the body), and aphasia (difficulty speaking). The MDS also reflected Resident #45's cognitive skills were severely impaired, indicating he was unable to make decisions. In addition, the MDS reflected that the resident was dependent on staff for all care, was incontinent of bowel and bladder, and had a feeding tube for nutrition. Record review of Resident #45's Care Plan, revised 01/13/26, reflected the resident had an ADL self-care deficit and required a total assist with all cares, was incontinent and required staff to check frequently for wetness, and required monitoring for signs of UTI. The Care Plan also reflected Resident #45 required tube feeding for nutrition, was on enhanced barrier precautions due to wounds, and required PPE for cares. Observation on 02/11/26 at 9:53 AM, revealed CNA C entered Resident #45's room, did not wash/sanitize her hands, and applied PPE (gown and gloves). Resident #45 was observed sitting in a wheelchair. CNA C closed the door, pulled the privacy curtain, and transferred Resident #45 into bed for wound care. CNA C checked Resident #45's brief which was observed to be wet. CNA C prepared incontinent care supplies on a clean barrier, unlatched Resident #45's brief, and cleaned the resident's perineal area. CNA C then assisted Resident #45 to turn onto his left side, used new wipes and cleaned the buttocks. CNA C rolled the soiled brief within itself and discarded it in the trash. Without performing hand hygiene or changing gloves, CNA C obtained a clean brief and placed it under Resident #45's buttocks, turned the resident onto his back, and secured the brief. CNA C then repositioned Resident #45 and removed her PPE, washed hands, and exited the room. CNA C did not perform hand hygiene prior to care and did not change gloves or perform hand hygiene prior to applying a clean brief during incontinence care. Interview on 02/12/26 at 12:39 PM, CNA C said she had been working at the facility for one month. CNA C stated hand hygiene should be performed anytime she entered or exited a resident's room. CNA C stated she forgot to wash her hands before putting gloves on prior to performing care on Resident #45. She stated she was also expected to change her gloves when going from the dirty brief to a clean one, or if the gloves were soiled. CNA C stated she was in a hurry to perform the care prior to wound care and forgot to change gloves or perform hand hygiene. CNA C stated she was educated on incontinent care and infection control when she was hired. She stated the risk of not changing gloves or performing hand hygiene was spreading bacteria. Interview on 02/12/26 at 12:44 PM, ADON B revealed she expected her staff to perform hand hygiene when entering or leaving a resident room. She stated she also expected all staff to change gloves and perform hand hygiene when soiled and between removing the soiled brief and applying a clean brief. ADON B stated she and the nurses were responsible for ensuring all CNAs were completing incontinent care appropriately. ADON B stated the risk of not changing gloves or performing hand hygiene was an infection control risk and could cause cross contamination. ADON B stated she was unsure when the last in-service was completed on incontinent care, but she stated all CNAs were trained on infection control and incontinent care upon hire and she performed regular rounds and completed 1:1 education when needed. Interview on 02/12/26 at 4:00 PM, the DON (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed she was the infection preventionist. The DON stated she expected her staff to change gloves and perform hand hygiene between the dirty and clean brief. She stated all staff were also expected to perform hand hygiene when entering and leaving a room. The DON stated it was her and the ADONs responsibility to ensure CNAs were properly performing incontinent care and infection control measures. The DON stated the risk of not performing hand hygiene and glove changes appropriately was potential introduction of bacteria. The DON stated all new hires get competencies completed, and the ADONs rounded to ensure care and infection control was properly performed. The DON stated she performed her own rounds and was going to start in-services and training for infection control. Interview on 02/12/26 at 4:35 PM, the Administrator revealed she expected her staff to perform hand hygiene when entering a resident's room prior to doing cares. The Administrator stated the risk of not performing hand hygiene appropriately could lead to infections. She stated it was all staff's responsibility to ensure infection control measures were completed. Record review of the facility's Hand Hygiene Policy, revised November 2022, reflected the following: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of the facility's Nursing Procedure Manual titled, Incontinence Care, revised 02/14/20, reflected the following: .14. Remove linen/underpad and discard 15. Remove and discard gloves 16. Wash hands 17. Apply clean linen/underpad, brief or other incontinent products, as needed.		

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 02/12/2026
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to establish policies regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents for 2 of 2 residents (Residents #11 and #72) reviewed for smoking. The facility failed to ensure the quarterly smoking assessments were completed to determine Resident #11 and Resident #72 for capability and safety. This failure could place the residents at risk for unsafe smoking causing harm. Findings include: Record review of Resident #11's face sheet, dated 02/19/2026, revealed resident was a [AGE] year-old male admitted to the facility on [DATE] with a readmission on [DATE]. Resident #11's admitting diagnoses included Unspecified Dementia, Unspecified Severity, without Behavioral Disturbances, Psychotic Disturbances, Mood Disturbances, and Anxiety (decline in cognitive functioning); Peripheral Vascular Disease (a slow-progressing condition involving narrowing blood vessels outside the heart - usually in the legs); and Schizophrenia, Unspecified (an individual experiencing significant psychotic symptoms, such as hallucinations, delusions, or disorganized behavior, that cause distress). Record review of Resident #11's quarterly MDS, dated [DATE], revealed his BIMS Score was 15, which indicated the resident's memory was intact. Resident #11's cognitive abilities were within a normal range. Resident #11 could make independent decisions regarding his ADL care. Record review of Resident #11's quarterly smoking assessments were completed 06/03/2023, 01/11/2024, 03/08/2024, 06/10/2024, and 09/10/2024. Quarterly smoking assessments have not been regularly completed. The smoking assessments currently completed by the nurse and social worker. Record review of Resident #72's face sheet, dated 02/12/2026, revealed resident was a [AGE] year-old male admitted to the facility on [DATE] with a readmission on [DATE]. Resident #72's admitting diagnoses included End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids); Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (is a common, progressive nerve damage condition causing pain, burning, tingling, or numbness typically starting in the feet and hands); Dependence on Renal Dialysis (patients who require dialysis treatment for chronic kidney disease or acute kidney injury); Acquired Absence of Right Upper Limb below elbow (amputation or loss of arm below the elbow); Complete Traumatic Amputation of Right Hand at Wrist Level Subsequent Encounter (loss of right hand at wrist level). Record review of Resident #72's quarterly MDS, dated [DATE], revealed his BIMS Score was 15, which indicated the resident's memory intact. Resident #72's cognitive abilities were within a normal range. Resident #72 could make independent decisions regarding her care. Record review of Resident #72's quarterly smoking assessments were completed 12/29/23, 03/08/24, and 03/06/25. Quarterly smoking assessments had not been regularly completed. Interview on 02/11/2026 at 10:00 a.m. with Resident #72 revealed he does not go out to smoke much, but with no hands or arms below the elbows the staff must assist him with smoking. Resident #72 states the staff are good at helping him with smoking. Interview on 02/12/26 at 4:15 PM, the DON revealed the policy for smoking residents is a designated smoke aide is assigned to set with the residents during the designated smoke breaks. She stated she expected that smoking assessments be completed on admission, quarterly, and if a resident had a change in smoking status. She stated the nurse or Social Worker completed the assessments, and the care plan was implemented by Social Worker or Nurse related to smoking. Interview on 02/12/26 at 4:39 PM, the Administrator revealed her expectations related to resident smokers is assessments and care plans were to be completed at admission, quarterly, and if resident had a change in smoking status. The Administrator stated she expected the Social Worker to complete the smoking assessments. Record review of the facility's Smoking Policy revised 01/07/2025, reflected in part: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees as related to smoking. To evaluate a patient's ability to participate and exercise the privilege to smoke/Use smokeless Tobacco products while residing (continued on next page)		

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

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within the facility. Evaluate patients that smoke/use smokeless tobacco, utilizing the Smoking Evaluation/Smokeless Tobacco Tool: (a) upon admission; (b) quarterly(c) when a previous non-smoking patient takes up smoking or when a patient takes up the use of smokeless tobacco (d) if unsafe smoking practices are observed in a current smoker; or a smokeless Tobacco user can no longer manage the use of, or cleaning abilities (e) when a patient that smokes or uses smokeless Tobacco products has a significant change in medical condition. Request therapy screen as indicated. Education will be provided to the resident on the assessment and the facility's expectation of compliance with the smoking program. Residents who smoke/use smokeless tobacco, will sign a smoke agreement upon admission and will be required to follow rules and regulations.		