STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675458	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	1501 S Main St Lockhart, TX 78644

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 4 residents (Resident #1 and Resident #2) reviewed for abuse. The facility failed to protect Resident #1 from physical abuse by Resident #2 when Resident #1 and Resident #2 were involved in a resident-to-resident altercation on 11/08/2025. On 11/08/2025, Resident #1 wandered into Resident #2's room. Resident #2 hit Resident #1 resulting in Resident #1 being sent to the hospital on [DATE] and treated for a head injury and scalp laceration and received staples to the posterior scalp. The noncompliance was identified as PNC. The IJ began on 11/08/2025 and ended on 11/08/2025. The facility had corrected the noncompliance before the survey began. This deficient practice could place residents at risk of physical injury and/or psychosocial harm. Findings included:Review of Resident #1's admission record, dated 11/19/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses that included: Alzheimer's disease (a form of dementia that worsens over time), unspecified dementia, unsteadiness of feet, depression, and COVID-19. Review of Resident #1's Quarterly MDS assessment, dated 08/09/2025, reflected a BIMS score of 3 which indicated significant cognitive impairment. Review of Resident #1's care plan, last revised on 11/13/2025, reflected at risk for falls related to Use of Psychoactive Medication, Wandering behavior and Unsteady Gait/Balance with interventions listed as Monitor for restlessness and implement interventions. Also, impaired cognitive function/dementia/thought processes related to Alzheimer's disease; at risk for injury related to wandering behavior, impaired safety awareness with interventions Encourage to stay in common areas of building for observation if needed and redirect back to area of familiarity if disoriented/irritable such as room or activity room; and potential for complication related to diagnosis of depression. Review of Resident #1's physician orders on 11/20/2025 reflected, sertraline for depression, trazadone for insomnia, and buspirone, Depakote tablet, and Ativan (Lorazepam) for anxiety.Review of a NP visit dated 11/05/2025 reflected Resident #1 was seen for an acute visit for agitation and behaviors of urinating in the dining room, making statements he will kill employees; running down the hallways, and increased restlessness. Medications were adjusted at that time. The family agreed to psychiatric to follow up next week if behaviors continue to increase or remain unchanged. Review of Resident #1's progress notes from 10/25/25 to 11/07/25 reflected the resident had a history of aggression with staff, increased wandering, and agitation from. Record review of Resident #1's incident report dated 00/00/00, reflected on 11/08/2025, at 2:51 P.M., Resident #1 wandered into Resident #2's room. Resident #2 admitted pushing Resident #1 to the ground and Resident #1 was observed lying on the floor, with blood on floor. Resident #1 had a head laceration to side and back of head and discoloration to left cheek. Review of Resident #1's hospital Discharge summary dated [DATE] reflected the resident was seen for assault, hit head, head injury, scalp laceration, and received stitches. Per EMS, Resident #1 wandered into the wrong room and was struck in the head by an object and fell. Review of the police report dated 11/08/2025 reflected Resident #1 went into another room and Resident #2 got mad and pushed Resident #1 to the ground. Resident #1 with heavy bleeding from the head. Resident #2 wanted to press charges against Resident #1; however, Resident #1 lacked the culpable mental state to commit a crime. Resident #2 possibly committed assault with serious bodily injury against elderly. Review of the NP visit note dated 11/10/2025 reflected Resident #1 was seen for acute visit for agitation, ER visit and medication adjustments. On 11/08/2025, Resident #1 was punched and fell backwards, hit his head and sustained laceration. Resident #2: Review of Resident #2's admission record, dated 11/20/2025, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had a primary diagnosis of hypertensive emergency (a severe increase in blood pressure that can lead to life-threatening organ damage), along with diagnoses of end stage renal disease, chronic kidney disease, hypertensive encephalopathy (a form of brain dysfunction caused by extremely high blood pressure), depression, cardiomegaly (enlarged heart), and most recently unspecified dementia as of 11/19/2025. Review of Resident #2's admission MDS assessment, dated 10/28/2025, reflected a BIMS score of 11 which indicated moderate cognitive impairment. Under Section E - Behavior: verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as was possible and ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed for accidents and hazards.The facility failed to ensure Resident #1 was free from accidents and hazards, when the facility did not have adequate supervision in place for Resident #1's aggressive and wandering behaviors. On 11/08/2025 at 10:41 AM, Resident #2 threatened to hit Resident #1 because Resident #1 was entering his room. Resident #1 wandered into Resident #2's room on 11/08/2025 at 2:51 PM, and Resident #2 hit Resident #1. Resident #1 was sent to the hospital on [DATE], treated for head injury and scalp laceration, and received staples to the posterior scalp. The noncompliance was identified as PNC. The IJ began on 11/08/2025 and ended on 11/08/2025. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk of injury and hospitalization.Findings included: Review of Resident #1's admission record, dated 11/19/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses that included: Alzheimer's disease (a form of dementia that worsens over time), unspecified dementia, unsteadiness of feet, depression, and COVID-19. Review of Resident #1's Quarterly MDS assessment, dated 08/09/2025, reflected a BIMS score of 3 which indicated significant cognitive impairment. Under section E- Behavior, there were no behaviors listed, except for wandering occurring daily. Review of Resident #1's care plan, last revised on 11/13/2025, reflected at risk for falls related to Use of Psychoactive Medication, Wandering behavior and Unsteady Gait/Balance with interventions listed as Monitor for restlessness and implement interventions. Also, impaired cognitive function/dementia/thought processes related to Alzheimer's disease; at risk for injury related to wandering behavior, impaired safety awareness with interventions Encourage to stay in common areas of building for observation if needed and redirect back to area of familiarity if disoriented/irritable such as room or activity room; and potential for complication related to diagnosis of depression. Review of NP visit dated 11/05/2025 reflected Resident #1 was seen for acute visit for agitation and behaviors of urinating in the dining room, making statements he will kill employees; running down the hallways, and increased restlessness. Medications were adjusted at that time. The family agreed to psychiatric to follow up next week if behaviors continue to increase or remain unchanged. Review of Resident #1's progress notes reflected a history of aggression with staff, increased wandering, and agitation from 10/25/2025 to 11/07/2025. Further review reflected on 11/08/2025, at 2:51 pm, Resident #1 wandered into Resident #2's room. Resident #2 admitted pushing Resident #1 to the ground and Resident #1 was observed lying on the floor, with blood on floor. Review of Resident #1's physician orders on 11/19/2025 reflected sertraline for depression (order date 10/29/2025), trazadone for insomnia (order date 11/05/2025), and buspirone (order date 11/05/2025), Depakote tablet (order date 11/13/2025), and Ativan (Lorazepam) for anxiety (order date 11/20/2025). Record review of Resident #1's incident report dated 00/00/00, reflected on 11/08/2025, at 2:51 P.M., Resident #1 wandered into Resident #2's room. 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