STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675622	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cityview Nursing and Rehabilitation Center	5801 Bryant Irvin Rd Fort Worth, TX 76132

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, it was determined the facility failed to ensure residents have the right to receive visitors of his or her choosing on day and time of his or her choosing for 1 of 2 (Resident #2) residents reviewed for resident rights. The facility failed to ensure Resident #2 had the right to receive visits from Family Member #1 since 11/27/23 inside the facility. This failure placed residents at risk of isolation, decreased emotional wellbeing and diminished quality of life. Findings included: Record review of Resident #2's face sheet, dated 06/04/24 revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), vascular dementia (decline in cognitive function due to reduced blood flow to the brain) hypertension (high blood pressure), chronic kidney disease and (long standing kidney disease that results in renal failure) and depression. Record review of Resident #2's most recent quarterly MDS assessment, dated 01/09/24 revealed the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #2's comprehensive care plan, revision date 01/11/24 revealed the resident .had a potential psychosocial wellbeing problem relating to indicating little interest or pleasure in doing things and sometimes having feelings of social isolation. Interventions included: provide opportunities for resident and family to participate in care. Interview with Family Member #1 on 06/03/24 at 3:33 PM revealed Resident #2 was visited regularly and cared for, including buying the resident clothes. Family Member #1 stated she was told one day by staff she was no longer allowed to visit, and the resident passed away two months later. The Ombudsman attempted to assist Family Member #1 by scheduling and attending a care plan meeting. Family Member #1 stated she was devastated she could not be with Resident #2 when he passed away. (continued on next page)

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

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/04/24 at 9:01 AM with Ombudsman revealed Family Member #1 was asked to leave the facility because she was disruptive to staff, not to the residents. The Ombudsman stated she advocated for Family Member #1 at the facility with the Administrator, but he said no. Interview on 06/04/24 at 2:18 PM with LVN B revealed Family Member #1 came to the facility on many occasions to visit the Resident #2. However, there was an incident in which clothing was removed by the POA that Family Member #1 bought for the resident. LVN B was told by the Administrator after that event that Family Member #1 was banned from the facility. LVN B stated that after the ban, Family Member #1 did not return to the facility. LVN B also revealed she never saw Family Member #1 attempt harm to the resident or threaten harm to the resident or any other resident. Interview on 06/04/24 at 3:24 PM with the ADON revealed the family member became upset over missing clothing and filed a grievance over the missing clothing that the POA removed from Resident #2's closet that was bought by them. The ADON revealed a meeting was held with the Ombudsman and the Administrator that resulted in the Administrator not allowing Family Member #1 back into the facility because the Administrator stated Family Member #1 was loud and obtrusive. The ADON revealed the Ombudsman asked if the Administrator would reconsider at a later time allowing Family Member #1 back in the building for visitation. The ADON revealed the Administrator said he would reconsider it at a later time. The ADON also stated the Ombudsman came back and attempted to assist the Family Member #1 in being provided with visitation to see the resident. However, the Administrator would not allow Family Member #1 to visit Resident #2 again. Interview on 06/04/24 at 9:45 PM with Family Member #2 revealed he and his wife were called into the Administrator's office to a care plan meeting including the ADON and were told that family members could not talk rudely to staff. The Administrator stated he was going to ban Family Member #1 from his facility if the POA and Family Member #2 agreed to the ban. The family agreed to the ban. Interview on 06/04/24 at 3:30 PM with the DON revealed unless there was a criminal trespass or protective order in place, the facility could not limit someone from visiting a resident that wanted to see them. The DON stated she did not attend the care plan meeting that involved the family, the ADON, and the Administrator. Record review of facility's policy titled, Resident Right to Access and Visitation date implemented 10/24/22 reflected the following: .The facility will provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at the time. Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to prevent the release of resident-identifiable information to the public, and also failed to maintain medical records that were complete and accurate for 1 Resident #1) of 4 residents reviewed for clinical records. 1. On 11/23/23 LVN A discussed Resident #1's medical conditions with a family member not authorized to receive the information. 2. On 11/23/23 LVN A failed to accurately document Resident #1's disposition after she left AMA, as well as events leading up to Resident #1 leaving AMA. These failures could place residents at risk of incorrect or incomplete documentation of their conditions as well as the release of personal information that could be used for illicit purposes. Findings included: Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of sternum (breast bone) fracture, history of multiple falls, heart attack, heart disease, and diabetes. Resident #1 discharged AMA on 11/23/23. Review of Resident #1's baseline care plan, dated 11/19/23, she was at risk for falls, pain from her fracture, and constipation. Review of nursing progress notes from 11/19/23 to 11/23/23 revealed limited documentation on Resident #1. The admitting nurse, RN-B, documented: Resident admitted to the facility to room .via gurney for services of Dr .resident alert and oriented to person, place and time, respiration rate even and non-labored, no SOB, abdomen soft and non-tender, bowels active in all quadrants, visible skins warm and dry, call light and fluids within reach, will continue to monitor. LVN A documented on 11/22/23 Resident seen .hurrying from room .claims she was looking for her [family member] to bring her some food and clothes. Asked resident not to enter other resident's rooms. Also claims her family member was coming in through the back passcode locked patio. Continue to observe behavior. 11/23/23: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident exibits increased confusion on 11/22 seen wandering into residents' rooms and ambulating toward passcode locked back patio. Refused FBS and argumentative with staff stating she was not diabetic and did not have HTN. Redirected. 11/23 resident c/o constipation even though currently having bm, continued to request laxatives. Refuses to drink water. Resident confusion increased, refuses to allow nurse to assess for possible constipation or UTI. Noted poor short-term memory. Verbally abusive to staff, stands at nurses station holding stool in her waving it staff yelling loudly I havent s*it in 4 weeks and you won't give me anything! I'm calling the police! notified management and np of residents behavior and left message for [Family Member #3]. Review of Resident #1's hospital discharge note revealed documentation of no bowel movement from 11/15/23 to 11/19/23 when the resident was discharged . Resident #1 is described as alert and oriented to person place and time. Review of EMS report from 11/23/23 revealed Resident #1 was yelling at the crew to get out and refusing all care. EMS crew verified the resident was competent to make her own adhesions and left the facility without the resident. EMS report indicated the call was initiated by LVN A. Interview via telephone on 06/04/24 at 11:43 AM with Resident #1 revealed LVN A made a lot of false accusations about her to other staff. Resident #1 stated she felt that LVN A was trying to make her look demented or crazy. She stated she never denied being diabetic, and she had been diabetic since she was [AGE] years old. She refused finger sticks because they were doing them too often, and LVN A was always too rough when she did them. Resident #1 stated her family member (Family Member #3) was supposed to bring her clothes, and she went to the door at the end of the hall to see if the family member could come in from there. On the way back to her room, she stopped at the door of another resident that was yelling for help to ask if he was ok. LVN A yelled at her to get away from his door and to mind her business. Resident #1 stated she had not had a bowel movement while in the hospital, and she was getting uncomfortable. She asked LVN A for a laxative and was told it had not been delivered from the pharmacy yet. Resident #1 stated she did get upset about that because the facility should have something on hand. On 11/23/23, Resident #1 said she was frustrated because the facility did not seem to be doing anything to help her out and said she was going to leave with her boyfriend. Resident #1 stated she finally had a large bowel movement and while she was on the toilet, EMS came in and started asking her questions. Resident #1 yelled at them and LVN A to get out. When she was done she was upset at LVN A because EMS had been called, and did not want to go with them. Resident #1 stated LVN A was telling the EMS crew she was wanting to leave AMA with her hair dresser that had just got out of prison and she did not feel it was safe for her to do so. EMS did not transport the resident. Resident #1 stated she called her boyfriend, who had never been to prison, to come get her and she left the facility. Resident #1 stated she was a retired math teacher and she still tutors kids, she was not demented or crazy like LVN A was making her out to be. Interview on 06/4/24 at 2:30 PM LVN A reviewed her documentation to recall the resident, she agreed her lost progress note did not describe what the nurse practitioner told her to do, who called 911, or that the resident left AMA and with whom. LVN A stated she had become concerned about the resident possibly having some dementia based on behaviors of going into other resident rooms, denying she had diabetes, and refusing finger sticks. When the resident told her she was calling her hair dresser, who had just got out of prison, to come take her home she was concerned that it was not a safe discharge plan. LVN A called the resident's son and left a message for him. LVN A did not recall if she had called 911 or if the resident had called 911. She did recall the nurse practitioner had ordered lab work that was not done. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN A reviewed a video submitted by the complainant where LVN A was recorded discussing Resident #1's private health information with a person who identified herself as the resident's family member [Family Member #4]. The recording was just over 30 minutes of LVN A discussing in detail her concerns about the resident, medical diagnoses, treatments done, and her discharge. LVN A agreed that she had not checked to see if the Family Member #4 was authorized to receive medical information about the resident, as Family Member #3 was the only person authorized. Interview and record review on 06/04/24 at 3:00 PM revealed the DON reviewed LVN A's documentation on Resident #1. The DON revealed she was unable to determine who had called 911, what the nurse practitioner had ordered, if the resident had been transported by EMS, if the resident left AMA and if so who she had left with. The DON stated the record definitely did not create a complete picture of the events of 11/23/23. The DON reviewed the video submitted and stated LVN A did not seem to have pause to check if the Family Member #4 was authorized to receive information before she began to discuss the resident's private information. The DON stated the risk of not checking was the resident's HIPPA information falling into the wrong hands. Review of the facility's policy Documentation in Medical Record, dated 10/24/22, reflected: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation