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	01/31/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to ensure the right to be free from abuse for 1 of 10 residents (Resident #2) reviewed for abuse. The facility failed to ensure Resident #2 was free from abuse when Resident #1 hit Resident #2 on both arms, causing a 9.0 cm x 6.0 cm bruise to the right forearm and a 11.0 cm x 7.0 cm bruise to the left forearm and a skin tear on the resident's middle finger, on [DATE] with a closed fist during a verbal altercation on the secured unit. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk for abuse and psychological harm. Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated [DATE], reflected the resident was a [AGE] year-old male who admitted on [DATE]. Resident #1 had diagnoses of dementia (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), diabetes mellitus (disease that results in too much blood sugar in the blood), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Resident #1 also had a BIMS score of nine meaning the resident had moderate cognitive impairment. Resident #1's Quarterly MDS reflected the resident had physical and behavioral symptoms directed toward others one to three days per week. Record review of Resident #1's EHR reflected Resident #1 was transferred to hospital on [DATE] for respiratory issues and did not return to the facility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan, dated [DATE], reflected Resident #1 was an elopement risk/wanderer relating to impaired safety awareness, wanders. Resident #1's care plan reflected Resident #1 had the potential to be physically aggressive towards others. The care plan reflected on [DATE] peer backed into Resident #1's wheelchair and Resident #1 kicked his peer causing his peer to fall. Resident #1 stated he would do it again, and next time hit his peer with his fist. Resident #1's goal was not to harm self or others through the review date. The care plan reflected interventions for Resident #1 included: educated on inappropriate behavior initiated on [DATE], administer medications as ordered, analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document, assess and address for contributing sensory deficits, assess Resident #1's needs including pain, food, give resident choices about care and activities, provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, modify environment, psychiatric consult as indicated, and intervene before agitation escalates including guide away from source of distress and engage calmly in conversation (if aggressive walk away calmly). The care plan did not reflect any physical aggressive incidents in August and therefore did have any new interventions following the incident Resident #2. Resident #1 refused to be assessed. Record review of Resident #2's Quarterly MDS Assessment, dated [DATE], reflected Resident #2 was a [AGE] year-old male at the time of the incident. Resident #2 was admitted on [DATE] with diagnoses of Alzheimer's disease (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), non-Alzheimer's disease (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cerebrovascular accident (damage to the brain from interruption of its blood supply), and hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). The MDS reflected physical behavior symptoms and other behavior symptoms toward others one to three days per week. Record review of Resident #2's Care Plan dated, [DATE], reflected Resident #2 was dependent on staff for meeting his cognitive deficits and physical limitations. Resident #2's care plan also reflected that Resident #2 had an ADL self-care performance deficit relating to Alzheimer's, impaired mobility. Resident #2's care plan also reflected that Resident #2 had an impaired cognitive function/dementia or impaired thought processes relating to Alzheimer's, with disorganized thinking and episodes of inattention. Interventions included partial to maximal assist by staff. Record review of Resident #2's EHR reflected Resident #2 expired on [DATE]. Record review of the Provider Investigation Report dated [DATE] revealed on [DATE] that LVN D heard Resident #1 and Resident #2 yelling at each other and slapping at each other. The report reflected LVN D witnessed Resident #1 strike Resident #2 with a closed fist to his forearms. Both residents were immediately separated and monitored for behaviors or agitation. The report also reflected supervision was increased with both residents becomnig calm. Resident #2 had a small skin tear to left middle finger and bruising to bilateral forearms. Resident #2 had a 9 x 6 cm bruise to the right forearm and 11 x 7 cm bruise to left forearm. The report further reflected following the incident Resident #1 was assisted by the Social Worker in finding alternate placement, and the facility provided education to staff regarding managing behaviors and abuse/neglect. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of witness statement dated [DATE] reflected LVN D heard Resident #1 and Resident #2 yelling at each other and slapping at each other. Provider Investigation Report also revealed LVN D witnessed Resident #1 then begin striking Resident #2 with a closed fist to his forearms. Both residents were immediately separated. Both men were calmed down and stayed in respective areas of separation. No further altercations were noted. Interview on [DATE] at 2:30 PM revealed CNA C saw Resident #1 and Resident #2 in their wheelchairs. CNA C said he heard the noise and turned around and separated the residents. CNA C stated he did not recall any specific details of the incident because it was five months ago. Interview via telephone on [DATE] at 10:45 AM with LVN D revealed she observed Residents #1 and #2 in front of her in the dining room. LVN D stated Resident #1 said, If you don't stop talking, I am going to hit you to Resident #2. LVN D said Resident #2 did not stop talking, and Resident #1 hit Resident #2. LVN D stated she notified the ADON and the family. LVN D revealed she could not recall the exact date of her last in-service on resident-to-resident altercations and abuse and neglect, but she knew it was recently and immediately following this incident. LVN D stated when the altercation began, she attempted to get to the residents as fast as she could. LVN D separated the residents and completed the assessment on Resident #2. Resident #1 was non-compliant and refused to be assessed. LVN D did not say if she knew what to do with Resident #1 if he became aggressive prior to the incident. Interview on [DATE] at 1:57 PM with ADON A revealed she was notified about the incident after it had occurred. ADON A stated as best as she could remember that Resident #2's wheelchair hit Resident #1's wheelchair. ADON A said Resident #1 then hit Resident #2. Interview on [DATE] at 4:14 PM with DON revealed the DON retrieved the Provider Investigation Report and read it. She revealed she did not recall any other information. Record review of the facility's Abuse, Neglect, and Exploitation policy, revised on implemented on [DATE], reflected: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Prior to the HHSC investigation, the facility took the following actions to correct the noncompliance: Incident/Accident log was reviewed with no issues noted. Grievances were reviewed with no issues noted. The facility did not complete a safe survey following the incident on the secured unit. Both residents were discharged prior to the investigation, so they could not be interviewed regarding the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In-Service with staff on Abuse and Neglect and Managing Behaviors with Dementia on [DATE] initiated from DON to all facility staff and completed. Interview on [DATE] at 11:31 AM with CNA E revealed she would first separate the residents. Then she would report the incident to her charge nurse. CNA E stated they attempt to keep residents who do not get along from sitting together to prevent altercations. CNA E stated she was last in-serviced on last Monday on abuse and neglect and resident to resident abuse. CNA stated the types of abuse are physical, mental, sexual, emotional, and verbal. CNA stated she would report abuse to the administrator who was the Abuse Coordinator. Interview on [DATE] at 11:45 AM with CNA F revealed she would first separate residents who were in an altercation. CNA F stated the three types of abuse are physical, mental, and emotional. CNA F said signs of abuse could be residents isolating themselves, changes in behaviors, crying, and outbursts. CNA F stated she would report these changes in behavior to her charge nurse, her ADON, and her Abuse Coordinator (Administrator). Interview on [DATE] at 6:08 PM with LVN G revealed when residents had behaviors, they should be separated first. LVN G stated an incident report was completed after the residents were assessed. LVN G revealed after an altercation, the residents' family members were notified as well as management. LVN G stated she was last in-serviced last week on abuse and neglect and resident -to-resident behaviors. Interview on [DATE] at 6:49 PM with CNA H revealed staff tried to keep residents apart when they did not get along. CNA H stated when resident had an altercation, she would report it to her charge nurse. CNA H could not recall the last in-service on resident-to-resident altercations and abuse and neglect in-services. Interview on [DATE] at 1:48 PM with RN I revealed residents should be separated if they had an altercation. RN I stated the residents should then be assessed for injuries, and the incident report should be completed. RN I said the families should be notified of the incident. RN I stated he was last in-serviced about a week ago on resident-to-resident abuse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 of 6 (Resident #3, #4, and #5) residents reviewed for use of assistance devices for positioning and transfers. 1. On 01/13/25 Hospice Aide K failed to use a drawsheet when repositioning Resident #3 in bed and instead raised her up underneath her armpits hard to pull her up in bed and heard a loud crack or pop. The facility ordered x-rays, and it was determined the resident had sustained a displaced humeral neck fracture (shoulder/upper arm fracture) due to the improper transfer and failure to use a drawsheet to position her in bed. 2. The facility failed to ensure Hospice LVN BB and Hospice Aide CC used a transfer belt when transferring Resident #4 and Resident #5. An IJ was identified on 01/29/25. The IJ template was provided to the facility on [DATE] at 4:03 PM. While the IJ was removed on 01/31/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's continuation of in-servicing and monitoring the plan of removal. These failures placed residents at risk of serious harm. Findings included: Record review of Resident #3's face sheet, dated 01/16/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #3's MDS Quarterly Assessment, dated 10/28/24, reflected Resident #3 had a BIMs score of 02, indicating severe cognitive impairment. Resident #3 was dependent on staff for toileting and showering, toilet transfers, tub/shower transfers, chair bed to chair transfers, lying to sitting on side of the bed, and sit to lying. Resident #3 required substantial/maximum assistance with upper and lower body dressing, rolling left and right. Her diagnosis included High Blood Pressure, Alzheimer's Disease, Anxiety, Depression, and bipolar disorder and Dysphagia (difficulty swallowing). Resident #3 received hospice care. Record review of Resident #3's Care Plan, reviewed on 01/17/25, reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Focus: [Resident #3] has an Activity of Daily Living self-care performance deficit related to muscle wasting, lack of coordination and impaired mobility. Goal: Resident will maintain current level of function Intervention: [Resident #3] was dependent on staff for toileting and showering, toilet transfers, tub/shower transfers, chair bed to chair transfers, lying to sitting on side of the bed, and sit to lying. [Resident #3] required substantial/maximum assistance with upper and lower body dressing, rolling left and right. Bath/Showering: Provide sponge bath when showering was not tolerated, with assistance by 1 staff, Bed Mobility: Resident required extensive assistance by 1 staff to turn and reposition in bed, Dressing: Extensive assistance by 1 staff. Transfers: Limited to extensive assistance by 1 staff to move between surfaces. [Resident #3] has an alteration in musculoskeletal status related to acute Left humeral neck fracture, moderate to severe glenohumeral osteoarthritis. 1/13/25 complaint of pain L shoulder during shower with hospice CNA. Goal: [Resident #3] will remain free from pain or at a level of discomfort acceptable to her. Interventions:1/13/25 assessed, Nurse Practitioner notified with new order STAT X-Ray Left shoulder, Representative notified. X-Ray results: Acute humeral neck fracture. Moderate to severe glenohumeral osteoarthritis. Nurse Practitioner /Responsible Party/hospice/DON notified; routine pain medication administered. Record review of the facility's Provider Investigation Report, dated 01/21/25, reflected: Incident date: 01/13/25, Time of Incident 7:15 AM. Person(s) or Resident (s) involved: [Resident #3] Alleged Perpetrator(s)(AP): [Hospice Aide K] Description of the Allegation: [Resident #3] complained of pain in her left shoulder after having a bath with the hospice aide, [Hospice Aide K]. Assessment: Date 1/13/25 Time: 8:43AM by [RN I] -Resident c/o pain to the left shoulder when she was given her a shower. Assessment performed ablet to squeeze my fingers c/o pain when lifting the arm. NP in the facility notified and ordered x-ray. Facility Investigation Findings: Confirmed. Provider Action taken post-investigation: [Resident #3] [is] being monitored for pain and medicated as indicated. Education continues with staff on abuse and neglect and turning and repositioning. Hospice aides are being re-educated also. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Facility initiated an investigation on 01/14/2025 after [Resident #3] made a complaint of pain in her shoulder and an x-ray that was ordered, returned with an Internal and external rotation views of the shoulder were obtained. There [is] a minimally displaced humeral neck fracture (a fracture in the neck of the upper arm bone where the broken bone pieces are only slightly out of alignment). Gleno-humeral joint space loss and spurring are noted (a space withing the shoulder joint is narrowed, and there are visible bone growths present, indicating the development of degeneration of joint cartilage and the underlying bone in the shoulder). There is no shoulder separation. There is no calcific tendinopathy (the formation of calcium deposits in tendons, leading to inflammation and pain). Diffuse osteopenia (generalized decrease in bone mineral density) is demonstrated. IMPRESSION: Acute humeral neck fracture. Moderate to severe gleno-humeral osteoarthritis. .[Hospice Aide K] came in for the interview and stated that he was repositioning [Resident #3] in the bed and did not use the draw sheet. He was informed of the injury and Hospice [Name] nurse was informed that he would need to removed from our building pending the investigation. Other residents who were under Hospice [Name] care were evaluated for pain, distress or injury with none noted. Staff were re-educated on our abuse-neglect policy and turning and repositioning when in bed and bathing. Hospice Aide K statement dated 01/14/25: On 01/13/20[24] I came to provide care for [Resident #3], [I] have been her aide since 12/21/2023. [I] usually give her bed bath but yesterday she had stool on her, so I took her to the shower. After showering her [I] dried her off and dressed her and assisted her back to the bed. She [is] a one-person transfer. After [I] put her back in bed, [I] adjusted her legs, but [I] noticed that she was still too far down in the bed. [I] went behind the headboard and lifted her under her arms to pull her up. [I] usually use the draw sheet but this time I just grabbed her under her arms. [I] did hear a pop at this time, and she said that her arm hurt. [I] reported to the nurse that she was complaining of pain, and he went to assess her. [I] reported it to my supervisor at Hospice [Name]. [Today], [I] was informed that there is a fracture. It was a complete accident. [I] didn't use the draw sheet like [I] was supposed to and was trained to do so by my company. [I] take pride in the work [I] do and always try to always ensure safety. [I] care so much for my patients and made a mistake that will never happen again. 1/14/25 hospice nurse in and assessed with pain medication adjustments, increase anxiolytic (medications to treat anxiety disorders), hold anticoagulant x 3-day, Blood Pressure medication, as needed anticholinergic (drugs that block the action of the neurotransmitter) related to secretions, Representative notified, 2 Person Assist provided with turning and repositioning, call light in reach. 1/15/25 hospice new order antibiotic therapy twice a day x 7day prophylactically (actions taken to prevent or guard against a disease or infection). 1/16/25 Left arm elevated on pillow for comfort, assisted with repositioning. Assist Resident #3 to change positions. Alternate periods of rest with activity out of bed as tolerated/allowed in order to prevent respiratory complications, dependent edema (swelling that occurs in the lower extremities), flexion deformity (joint is permanently bent in a flexed position) and skin pressure areas. Be sure call light is within reach and respond promptly to all requests for assistance. Educate resident /family/caregivers on joint conservation techniques. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Give analgesics (pain reliever) as ordered by the physician. Monitor and document for side effects and effectiveness. Monitor for any side effects to NSAIDS such as GI bleeding or renal impairment. Monitor/document for risk of falls. Educate resident/family/caregivers on safety measures that need to be taken in order to reduce risk of falls. Monitor/document/report as needed signs and symptoms or complications related to arthritis: Joint pain. Joint stiffness, usually worse on wakening; Swelling; Decline in mobility; Decline in self-care ability; Contracture formation/joint shape changes; Crepitus (creaking or clicking with joint movement); pain after exercise or weight bearing. Record review of Resident #3's x-ray results dated 01/13/25 reflected x-rays of the resident's left shoulder showed the following findings: .Findings: Internal and external rotation views of the should were obtained. There is a minimally displaced humeral neck fracture. Gleno-humeral joint space loss and spurring (bony growths that form in your joints) are noted. There is no shoulder separation. There is no calcific tendinopathy. Diffuse osteopenia is demonstrated. Impression: Acute humeral neck fracture. Moderate to severe gleno-humeral osteoarthritis. Record review of Resident #3's progress notes reflected the following entries: - 01/13/25 10:32 AM written by RN L: Hospice aide reported to the RN L that resident complained of pain to the left shoulder when he was giving her a shower. Assessment performed able to squeeze my fingers complained of pain when lifting the arm. Nurse Practitioner in the facility notified and ordered x-ray. Called . mobile x-ray and an order was placed family notified and will continue to monitor. - 01/13/25 11:34 AM written by RN L : left shoulder pain, started 01/13/25, since started it has gotten worse. Things that make the condition worse: movement. Things that make the condition better: calm. - 01/13/25 6:30 PM: Left shoulder X-ray results received with the following findings: Acute humeral neck fracture and moderate to severe gleno-humeral osteoarthritis. Nurse Practitioner notified pending new orders, call placed to family and Hospice awaiting call back from Hospice. DON notified. Routine pain medications administered as per orders. - 01/14/25 8:42 AM written ADON B: Resident complained of left arm pain 1/13/25. Nurse Practitioner was in the building and notified. X-ray positive for fracture. Pain controlled by Tylenol #3. - 01/14/25 2:13 PM written by ADON B: Hospice nurse in the facility to examine resident. She gave the following orders: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Discontinue Routine Tylenol #3 2. Start Tylenol #3 2 tabs every 6 hours as needed for pain. 3. Start Hydrocodone 10/325 1 by mouth every 6 hours routine. 4. Discontinue Tylenol #3 when hydrocodone arrives. 5. Morphine 20 mg/ml give 0.25 - 0.5 ml under the tongue every hour as needed for severe pain/short of breath. 6. Tylenol 650 mg suppository give one recetally every 4 hours as needed for fever greater than 100.5 Do not exceed 3gm Tylenol in 24 hours. 7. Give Tylenol #3 2 tabs now for severe pain. - 01/14/25 2:30 PM written by ADON B: Resident's family member was contacted via phone regarding change of condition/arm fracture. Explained to her how resident obtained injury and the plan moving forward to provide comfort care. New orders from hospice reviewed with family member. Family member in agreement with not pursuing aggressive measure and is ok with comfort measures. - 01/14/25 10:02 PM: Resident was stared on Norco 10/325 mg routine, medication administered this as per orders for left shoulder pain. Resident stable and able to voice needs. Incontinent care provided by staff. Call light in reach. Observation of Resident #3 on 01/15/25 at 2:00 PM revealed the resident was in bed resting. The resident responded that she felt okay and closed her eyes. Observation and interview on 01/16/25 at 2:00 PM with Resident #3 revealed her in bed. Resident #3 revealed she did not have any pain and did not display any signs or symptoms of distress. Resident #3 was not able to effectively communicate about her arm injury. Interview on 01/16/25 at 2:05 PM with CNA J revealed Resident #3 was currently on hospice, she was informed there had been an injury with Resident #3's left arm. CNA J stated Resident #3 allowed incontinent care however was very protective of her left arm. CNA J stated Resident #3 had a great relationship with Hospice Aide K and looked forward to his visits. According CNA J stated she was aware to use a draw sheet to reposition residents and never to pull on their body parts. CNA J stated Resident #3 had been asking for Hospice Aide K because it had been a couple of days since he had returned. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/16/25 at 3:12 PM with RN L revealed Resident #3 received bed baths and showers from hospice, RN L stated on 1/13/25 Resident #3 received a shower from Hospice Aide K after placing her back in bed, Hospice Aide K alerted me that Resident #3 complained of pain to the right shoulder. RN L stated he went in room to complete assessment and Resident #3 stated that when Hospice Aide K pulled her up in bed, she heard a pop and had pain soon after. RN L stated the Nurse Practitioner was in the building and after alerting her she ordered x-ray. RN L stated Hospice Aide K revealed that he showered Resident #3 and placed her back in bed, she was low in bed, so he stepped behind the bed lifting her placing his arms underneath her shoulders and lifted her up in bed, heard a pop, then she complained of pain. Interview on 01/16/25 at 3:25 PM with Hospice Aide K revealed he has been working with Resident #3 for over a year coming to the facility Monday, Wednesday and Friday to provide mostly bed baths. He stated on 01/13/25 Resident #3 was heavily soiled and required a shower. Hospice Aide K stated after transferring Resident #3 to her bed she was still too low in bed. Hospice Aide K stated In order to get her pulled up I always raise the bed and feet up with the controller to allow gravity to assist me. I put my arms under her arm pits. I usually grab the sheet. This time I did not grab the sheet. I put my weight against the headboard. This time when I lifted her, I did so hard there was this loud cracking sound. I can not say why I repositioned her this way, without the use of a draw sheet He stated when he pulled her up there was a loud cracking, popping noise from the left shoulder. Hospice Aide K stated, When I heard that, I ran to alert the nurse. During the assessment Resident #3 reported her left shoulder was hurting, an x-ray was ordered, and the following day it was reported Resident #3 had a fracture. Interview on 01/16/25 at 4:10 PM with DON revealed she was informed Resident #3 complained of pain of the left shoulder. The DON stated the Nurse Practitioner had ordered an x-ray that revealed findings of a fracture. The DON stated she went to speak with Resident #3 when she expressed Hospice Aide K was bathing her and she heard a loud pop. The DON stated she called Hospice Aide K; he confirmed the there was a loud pop to the shoulder which resulted in Resident #3 having pain. Interview on 01/16/25 at 4:27 PM with ADON B revealed he had been informed by RN L that Resident #3 had received a shower from Hospice Aide K, he attempted repositioning her in bed by pulling Resident #3 up by placing his arms underneath her shoulders and not using the draw sheet. ADON B stated x-ray results came revealing a fracture leading us to make all the notifications to the DON, physician, hospice and Family Member. ADON B stated Resident #3 was kept comfortable and orders for Tylenol 3, Norco and Morphine was administered. ADON B stated inservices were started to train staff to always have help with repositioning, use draw sheet, do not pull-on resident body parts. ADON B stated all aides including hospice staff were responsible for asking for assistance from other aides, charge nurses or ADONs to reposition residents, not doing so placed residents at risk of injury or fall. Interview on 01/16/25 at 4:45 PM with the DON revealed she was currently completing the investigation and inservices for Resident #3. The DON stated staff were being inserviced on repositing residents, using draw sheet, asking for assistance when repositioning residents. (continued on next page)

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	675622	A. Building B. Wing	01/31/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Inservice Training Report dated 01/14/25 Abuse and Neglect; also 01/14/25 Turning and Repositioning/lift extremities/monitor for discomfort reflected the following: Each resident should have a draw sheet placed under them when in bed. When turning and repositions a resident in bed, [you] should never pull them by their arms or legs. Use the draw sheet for all turning, repositioning, and pulling them in the bed. GENTLY, lift the arm and legs when off loading or moving for comfort. If a patient shows signs of discomfort during any aspect of care, STOP what [you[are doing and get your nurse. (Make sure the resident is safe). Remember, pain is not always expressed verbally. Monitor facial expressions. At no time should we refer to a resident as being dead weight. 2. Record review of Resident #4's face sheet, dated 01/29/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #4's quarterly MDS assessment, dated 01/08/25, reflected a BIMS score of 06, which indicated severe cognitive impairment. Her diagnoses included unspecified dementia, dysphagia, hypertension (high blood pressure). The MDS further revealed Section GG - Functional Abilities indicated Resident #4 needed substantial/maximal assistance (helper does more than half the effort lifts or holds trunk or limbs and provides more than half the effort) for chair/bed-to- chair transfer. Record review of Resident #4's care plan revised date 01/13/25 reflected: Problem: [Resident #4] has an ADL self-care performance deficit r/t impaired mobility. Goal: [Resident #4] will maintain current level of function in ADLs through the review date. Interventions: FUNCTIONAL PERFORMANCE: CHAIR/BED-TO-CHAIR TRANSFER: [Resident #4] requires substantial/maximal assistance to transfer to and from a bed to a chair (or wheelchair). BATHING/SHOWERING: [Resident #4] requires total assistance by 1 staff with bathing/showering. Observation on 01/29/25 at 10:23 AM revealed Hospice LVN BB performed a transfer for Resident #4 from the wheelchair to the bed to provide the resident a bed bath. Hospice LVN BB explained the procedure to Resident #4. Hospice LVN BB then locked the resident's wheelchair and told Resident #4 to hug her. Hospice LVN BB was observed to put her arms around Resident #4 underneath the resident's arms and lifted the resident up. She then turned the resident and sat her on the bed. Resident #4 was not able to stand her own and depended on the hospice nurse to do the transfer. Hospice LVN BB did not use a transfer belt when performimg the transfer. Record review of Resident #5's face sheet, dated 01/29/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #5's significant change in status MDS assessment, dated 12/27/24, reflected a BIMS score of 11, which indicated moderate cognitive impairment. Her diagnoses included old myocardial infarctio n (previous heart attack that's no longer active), malnutrition, dysphagia, hypertension (high blood pressure). The MDS further revealed Section GG - Functional Abilities indicated Resident #5 needed substantial/maximal assistance (helper does more than half the effort lifts or holds trunk or limbs and provides more than half the effort) for chair/bed-to- chair transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #5's care plan revised date 01/16/25 reflected: Problem: [Resident #5] has an ADL self-care performance deficit r/t impaired mobility, declining health. Goal: [Resident #5] will maintain current level of function in ADLs through the review date. Interventions: FUNCTIONAL PERFORMANCE: CHAIR/BED-TO-CHAIR TRANSFER: [Resident #5] requires substantial/maximal assistance to transfer to and from a bed to a chair (or wheelchair). BATHING/SHOWERING: [Resident #5] requires total assistance by 1 staff with bathing/showering. Observation on 01/29/25 at 10:30 AM revealed Hospice Aide CC performed a transfer for Resident #5 from the bed to the wheelchair, so she could take the resident to the shower room. Hospice Aide CC explained the procedure to Resident #5. Hospice Aide CC then helped Resident #5 sit on the side of the bed. Hospice Aide CC lifted the resident by holding onto the resident's waistband, and the resident stood up. Hospice Aide CC next told the resident to hold onto her like she was hugging her. Hospice Aide CC held the Resident #5 by the waist with both hands, lifted her, and placed the resident to the wheelchair. Hospice Aide CC did not use a transfer belt, and Resident #5 was not able to stand her own and depended on the hospice Aide to do the transfer. Interview on 01/29/25 at 11:03 AM with Hospice LVN BB revealed she was the aide and the nurse assigned to Resident #4. She stated today 01/29/25 was the first-time meeting Resident #4. She stated she was covering for another hospice staff. She stated when she came in, she told the facility who she was visiting and obtained report from the charge nurse. She stated she was told about Resident #4's transfer. She stated Resident #4 was a one person assist. She stated she also got report last week from the resident's Case Manager, and she was told the resident was a one-person transfer. She stated she had access to Resident #4's hospice care plan, and the care plan only stated Resident #4 could transfer to the bed and the chair with assist, but she could not see by how many people and with what device. She stated she could get more information from her office. Hospice LVN BB stated when she was told Resident #4 was a one person transfer it was not specified whether to use a gait belt or not. She stated she only followed what the resident's care plan stated which was one person transfer. Hospice LVN BB stated if more information was required, the hospice company needed to be contacted to obtain the information. Interview on 01/29/25 at 11:51 AM with Hospice Aide CC revealed she was the hospice aide for Resident #5. She stated she visited Resident #5 five days a week. She stated when transferring Resident #5 from the bed to the wheelchair or the wheelchair to the bed, Resident #5 was able to hold onto her and able to stand. She stated Resident #5 was a one person assist for transfer. She stated it was unknown if any devices were needed to complete the transfer. Hospice Aide CC stated the charting system provided a summary of the patient's care. She stated for a transfer it did not specify if a gait belt was needed. She stated the facility had not provided any information if a gait belt was needed to transfer Resident #5. She stated any transfer training she had received was from her hospice company. Interview on 01/29/25 at 12:03 PM with RN I revealed when hospice came in to visit residents, the Hospice staff sometimes communicated with the nurse on duty; however, sometimes they did not because Hospice staff already knew the resident care. He stated he did not provide hospice staff any oversight on care or transfers. He stated the hospice aides should get the details of the care plan and any information regarding transfers and positioning from their hospice nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/29/25 at 12:20 PN with the Nurse Practitioner revealed Resident #3 was on hospice services and her orders and care were managed by hospice. She stated the day of the incident she was in the facility, and she gave orders for x-rays since Resident #3 needed one urgently but when results were back, she told staff to report to the hospice nurse. Interview on 01/29/25 at 12:24 PM with LVN Z revealed she had residents on her hall who were seen by hospice. LVN Z stated when the hospice staff visited, she provided them with report and gave them any updated information on the resident. She stated if the resident was two person assist, she would notify the hospice staff and would let them know to come get her when they were ready to transfer. She stated the only information she would provide the hospice staff would be any change of condition updates and if the resident was a one person or two persons assist. She stated she could not recall if they used any devices when transferring but they should use a draw sheet when repositioning or turning the resident. Interview on 01/29/25 at 1:33 PM with ADON B revealed when a hospice staff came to the facility, the charge nurse was responsible to provide report or any change of condition to the hospice staff. ADON B stated he was not sure if the facility staff provided any information regarding transfers or if they required the use of a gait belt when transferring a resident. He stated it was the responsibility of the hospice staff to ensure they knew the resident's care plan and if the resident was a one person or two person assist. ADON B stated it was the responsibility of the hospice company to in-service all hospice staff. He stated facility staff were in-serviced on repositioning and transfers after Resident #3's incident. He stated today (01/29/25) he contacted all hospice companies to let them know of the incident regarding repositioning and they expected for all hospice staff to be trained. ADON B stated he could not answer the question of who was responsible or who provided hospice staff of any oversight on care or transfer. Interview on 01/29/25 at 1:46 PM with ADON A revealed she had 9 residents on the secure unit. She stated when a hospice staff came in, they provided the hospice staff with any information regarding the resident. She stated the hospice staff reviewed the care plan on their own system and they knew if the resident was a one person, or two persons assist. ADON A stated if the hospice staff needed assistance with transfer they would assist. She stated it was unknown who provided training to the hospice staff. (continued on next page)

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