| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675622 | A. Building<br>B. Wing | 06/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cityview Nursing and Rehabilitation Center | 5801 Bryant Irvin Rd<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 2 of 5 resident (Residents #1 and #2) reviewed for supervision.<br><br>The facility failed to provide adequate supervision to Residents #1 and #2, who both had severe cognitive impairment and resided on the facility's memory care unit. On 02/02/25, Resident #1 was found fully clothed in Resident #2's bed, and Resident #2 had no clothing on below the waist.<br><br>The noncompliance was identified as PNC. The noncompliance began on 02/02/25 and ended on 02/03/25. The facility had corrected the noncompliance before the survey began.<br><br>The failure could place residents at risk for abuse.<br><br>Findings include:<br><br>Record review of Resident #1's face sheet, dated 06/17/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE].<br><br>Record review of Resident #1's quarterly MDS assessment, dated 06/11/25, reflected her diagnoses included Alzheimer's disease with late onset (brain disorder), unspecified dementia with mood disturbance and depression (loss of cognitive functioning). Resident #1's BIMS score was 00, which indicated severe cognitive impairment. Section E - Behaviors reflected Resident #1 exhibited wandering behaviors .<br><br>(continued on next page) |

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

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's care plan, dated 02/03/25, reflected Problem: [Resident #1] has sexually inappropriate behaviors. 2/2/25 in male peer's room fully dressed, male peer was undressed below hips attempting to engage with [Resident #1]. Goal: [Resident #1] will have no evidence of sexually inappropriate behaviors by review date. Interventions: 2/2/25 staff immediately intervened and separated [Resident #1] from peer, skin assessed, Administrator/DON/RP notified, [psychological/psychiatric services] referral, peer was placed on 1:1 supervision. Caregivers to provided opportunity for positive interaction, attention. Stop and talk with her as passing by. If reasonable, discuss [Resident #1] behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to her. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for [Resident #1] disruptive behaviors by offering tasks which divert attention. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Provide a program of activities that is of interest and accommodates [Resident #1] status .<br><br>Record review of Resident #1's progress note, dated 02/02/25 at 22:43 [10:43 PM] by LVN B, reflected:<br><br>Resident observed in male pt room, pt (fully dressed) male resident undressed below the hips. Male pt attempting to engage with female pt. nursing staff immediately intervened and separated the two. Both with Positive/affect. No s/s of pain/distress.<br><br>Interventions: Skin assessment completed no acute skin concerns at time of assessment. Currently seated at nurses' station. On coming shift notified. reviewed residents' disposition after event, notified male resident is now 1:1. Family requested male pt name / denied HIPPA . Reviewed current intervention provided by nursing staff, family states their understanding, will continue with current Plan of care.<br><br>Observation on 06/17/25 at 12:01 PM, revealed Resident #1 was observed in the memory care unit, sitting in the dining area. Resident #1 did not respond to any questions.<br><br>2. Record review of Resident #2's face sheet, dated 06/17/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE].<br><br>Record review of Resident #2's quarterly MDS assessment, dated 03/11/25, reflected his diagnoses included unspecified dementia with agitation (loss of cognitive functioning), schizophrenia (chronic mental disorder that significantly impacts a person's thinking, feeling, and behavior), and high blood pressure. Resident #2's BIMS score was 14, which indicated his cognition was intact. Section E - Behaviors indicated Resident #2 did not exhibit any wandering behaviors .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #2's care plan, dated 02/03/25, reflected Problem: [Resident #2] has sexually inappropriate behaviors. 2/2/25 in his room with female peer undressed below his hips attempting to engage with female peer who was fully dressed. Goal: [Resident #2] will have no evidence of sexually inappropriate behavior problems by review date. Interventions: 2/2/25 staff immediately intervened and separated [Resident #2] from peer, skin assessed, DON notified, placed on 1:1 supervision, oncoming shift/Administrator/RP notified, [psychological/psychiatric services] referral. If reasonable, discuss [Resident #2] behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to him. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for [Resident #2] disruptive behaviors by offering tasks which divert attention. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. No prior sexual inappropriate behaviors documented in Resident #2's care plan.<br><br>Record review of Resident #2's progress note, dated 02/02/25 at 10:20 PM by LVN B, reflected: Resident observed with female pt in room, resident undressed below the hips. Attempting to engage with female pt (fully dressed). Nursing staff immediately intervened and separated the two. Both with Positive/affect. No s/s of pain/distress. Resident denies situation/observed by staff. Interventions: Skin assessment completed no acute skin concerns at time of assessment. DON pt to be 1:1 until further notice, awaiting aid. On coming shift notified.<br><br>Record review of Resident #2's progress note, dated 02/03/25 at 11:39 AM by Social Worker, reflected: SWA visited with resident and asked him if he was aware of an incident that took place in his room. Resident stated that a female resident came and got in his bed. He stated he was accused of being in bed with her with his pants off, but that it was not true. When asked how he feels about the situation, he said he just don't want people saying things about him that was not true. His countenance was calm and did not appear upset or distraught.<br><br>Record review of the facility's Provider Investigation Report, completed by the Administrator on 02/07/25, reflected the following:<br><br>02/02/2025<br><br>The facility initiated an investigation on 02/02/2025, after two residents were involved in an alleged sexual interaction.<br><br>[Resident #2] is a [AGE] year-old male that was residing on the dementia unit with a BIMS score of 1. His diagnosis includes unspecified dementia (loss of cognitive functioning), need for assistance with personal care, primary hypertension (high blood pressure), schizoaffective disorder-bipolar type ((chronic mental disorder that significantly impacts a person's thinking, feeling, and behavior), altered mental status (change in mental function), chronic glaucoma (eye condition that damages the optic nerve). He admitted on [DATE], he self ambulates. He is dependent upon staff for ADL's , can feed self. He has no history of sexual interactions and is seen by [psychological/psychiatric services].<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [Resident #1] is a [AGE] year-old female resident who admitted on [DATE] and resides on the dementia unit with a BIMS score of a 2. Diagnosis's [sic] include Alzheimer's disease (brain disorder), Dementia (loss of cognitive functioning), Raynaud's Syndrome without gangrene (causes spasms in small blood vessels in your fingers and toes). She self ambulates. She is dependent upon staff for ADL's and can feed self. She has been referred to [psychological/psychiatric services].<br><br>On 02/02/2025 [Resident #2 and Resident #1] were observed in .[Resident #2's room] in the bed together, [Resident #1] was fully clothed while [Resident #2] was undressed from the waist down. There was no other resident in the room. [CNA A] walked into the room and intervened immediately. [Resident #2] was placed on a one-on-one until reviewed by psych . No further interactions or behaviors were noted the evening.<br><br>Both residents were assessed with no signs of distress noted for either. Full skin assessment on [Resident #1] with no concerns.<br><br>Families were notified. [Psychological/psychiatric services], MD , regional support team and HHSC were all notified.<br><br>Both residents were seen by Social Services and [psychological/psychiatric services]. No distress was noted.<br><br>Incident reports were completed, skin assessments were completed, care-plans were updated. Education was initiated on Abuse and Neglect and managing difficult behaviors.<br><br>Both residents were visited by administrative staff daily and no distress or mood changes were noted.<br><br>Record review of Employee Witness Statement by CNA A, dated 2/2/25, reflected: [CNA A] was covering rooms 101 to 109 on the locked unit and on her rounds, she entered room [ROOM NUMBER]. [CNA A] witnessed male resident [Resident #2] in the bed with no bottoms on, over a fully clothed, female resident. [CNA A] intervene immediately and asked the male resident to get dressed and asked for help. [LVN B] came immediately and they assisted the female resident out of the room.<br><br>Interview on 06/17/25 at 11:42 AM, with Resident #2 revealed he used to reside in the memory care unit. He stated he recalled the incident where a lady entered his room and got into his bed. He stated he was sitting by the door when the lady entered his room. He stated he told the aide a lady was in his bed. He stated he could not recall the aide's name. He stated he did not know why the aide lied on him and said he had his pants down and was in bed with the lady. Resident #2 stated he never got in the bed or was naked. He stated he had clothes on. He stated nothing happened and never would. Resident #2 stated he did not want people to think he did something to that lady.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/17/25 at 1:54 PM, CNA A revealed she was the CNA who found Resident #1 in Resident #2's bed. She stated at around 2:00 PM-2:30 PM, she was doing her rounds and she entered Resident #2's room. She stated she observed Resident #1 fully clothed in Resident #2's bed and Resident #2 was leaning towards Resident #1, one hand on the bed by Resident #1 head and the other hand on the bed by the hip area and appeared like he was putting on her pants. She stated the residents' bodies were not touching each other. She stated Resident #2 only had a shirt on, no pants or brief on. She stated she immediately intervened and asked Resident #2 what was he doing and to put some clothes on. She stated Resident #2 did not respond to any questions. She stated she redirected Resident #1 to get out of the bed and called LVN B to come assist. She stated by the time LVN B entered the room Resident #2 was changed and sitting by the door. She stated this was the first incident, Resident #2 did not have any known sexual behaviors.<br><br>Interview on 06/17/25 at 2:03 PM, LVN B revealed she was the nurse assigned to the memory care unit when Resident #1 was found in Resident #2's bed. She stated she had worked a double shift, she stated prior to Resident #1 wandering into Resident #2's room, they were both observed in the dining area, she had finished doing activities with the residents. She stated the residents were not next to each other. She stated she could not recall much but she had gone to break and when she returned, she was at the nurse's station and heard one CNA call another CNA to Resident #2's room. She stated she went to go check what was going on, she observed Resident #1 sitting on the bed and Resident #2 sitting on a chair by the door. She stated both residents were dressed, she did not witness anything. She stated she was told by CNA A; Resident #2 was undressed while Resident #1 was in bed fully clothed. She stated it was unknown of the intent between Resident #1 and Resident #2. She stated she assessed both residents and Resident #2 was placed on 1:1 supervision for the rest of the night. She stated nothing happened between Resident #1 and Resident #2. She stated Resident #2 had no known sexual behaviors, she stated this was the first incident during her shift.<br><br>Interview on 06/17/25 at 2:47 PM, ADON C revealed Resident #2 admitted to the facility memory care unit in November 2024. She stated when Resident #2 admitted to the memory care unit, the resident would not communicate and was an elopement risk. She stated Resident #2 was not known to wander into other residents' room or female rooms and did not have any sexual behaviors. She stated she was not working the day of the incident; but she was called and was told about the incident. She stated it was reported to her the newly admitted Resident #1 had wander into Resident #2's room and Resident #1 and Resident #2 were found together. She stated she could not recall but she was told Resident #2 was coming out of the restroom when he noticed Resident #1 in the bed. She stated she was told Resident #1 was fully clothed and Resident #2 was not wearing any pants and what appeared Resident #2 was trying to remove Resident #1's clothes. She stated she could not recall how they were found but nothing happened between them. She stated when she talked to Resident #2, he denied the incident and stated, a female resident entered his room and got in his bed. She stated Resident #2 told her he was in the service and would ever hurt anyone.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/17/25 at 3:18 PM, the DON revealed she was notified a CNA was doing rounds and entered Resident #2's room and noticed Resident #1 in Resident #2's bed together. She stated Resident #2 was naked from the waist down. She stated the CNA intervened, separated them, and called the nurse. She stated nothing happened between Resident #1 and Resident #2. She stated Resident #1 was fully clothed when she was found in the bed. She stated nothing else was told to her about the incident and the intent was unknown. The DON stated she could not recall when the last time both residents were last seen. She stated it was Resident #1's second day in the memory care unit. She stated Resident #2 had never had any known sexual behaviors. The DON stated when she notified Resident #1's family about the incident, the family was not surprised and informed her Resident #1 had a history of those interactions , which the facility was not aware of. She stated as an intervention they placed Resident #2 on 1:1 supervision until the doctor said he was appropriate to be off, both residents were assessed, and psych services provided . She stated no further interactions or behaviors were noted.<br><br>Interview on 06/17/25 at 5:12 PM, the Administrator revealed Resident #1 was newly admitted to the memory care unit and was confused. He stated Resident #1 was acclimating to the unit; however, wandered into Resident #2's room. He stated it was informed to him that the CNA entered Resident #2's room and found Resident #1 in Resident #2's bed. He stated he could not recall much but Resident #2 was in the room, coming out of the restroom when Resident #1 got in his bed and then Resident #2 got in the bed. The Administrator stated nothing sexual happened between the residents. He stated the CNA intervened immediately and removed Resident #1. He stated Resident #2 had not had any previous behaviors. He stated his expectations were for staff to monitor residents, keep a close eye on them, keep residents in the common area and frequent rounding. He stated the potential risk would be resident to resident interactions.<br><br>Record review of the facility's Abuse and Neglect policy, dated 08/15/22, reflected the following:<br><br>. VI. Protection of Resident - The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation .<br><br>The facility took the following actions to correct the noncompliance:<br><br>Observations completed on 06/17/25 from 11:00 AM through-4:45 PM in the memory care unit revealed 2 halls, one for male residents and the other one for female residents. Observed residents in the common area, staff monitored residents, redirected residents and frequent rounding in the halls. Activities were provided to residents . Observed 2 nurses, 3 CNA's and 1 Activity staff in the memory care unit.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interviews on 06/17/25 from 12:45 PM through 5:20 PM with CNA A, LVN B, ADON C, ADON D, LVN E, RN F, LVN G, CNA H, LVN I, CNA J, LVN K, Activities, LVN L, CNA M, CNA N, CNA O, LVN Q, and LVN R who work the shifts of 6:00 AM-2:00 PM, and 2PM-10PM. Facility staff were able to verify education was provided to them. The nursing staff stated they were educated on different types of abuse/neglect and behaviors. Staff monitoring behaviors through-out the shift, if a resident exhibits behavior resident placed on 1:1 supervision or every 15 minutes check, they document and notify the incoming staff. Redirecting residents when they start wandering into the opposite side of the unit, they provide activities through-out the day and round checking on residents every 1 or 2 hours. Redirecting residents when they start wandering into the opposite side of the unit, they provide activities through-out the day and round checking on residents every 1 or 2 hours. Staff stated they completed rounds during shift change with the incoming staff. Staff provided the types of abuse were physical, mental, financial, and verbal. Staff stated they would intervene if they witnessed any inappropriate behaviors, separate, redirect, ensure safety, and assess residents. Staff revealed they would report to the Abuse Coordinator, the Administrator, immediately if they witnessed or observed any of these behaviors.<br><br>Record review of Resident #1 and Resident #2's Skin assessment, Pain assessment and change in condition Assessment completed on 02/02/25 and 02/03/25, documented no concerns.<br><br>Record review of Resident #1 psych services reflected Resident #1 was seen on 02/03/25 and received an order for Depakote 1 capsule by mouth three times a day for mood/behaviors.<br><br>Record review of Resident #2 psych services reflected Resident #2 was seen on 02/03/25. Visit note reflected Pt is 1:1 after a female pt was found in his room sleeping in the empty bed. Pt was unable to explain what was happening. The other pt is new and very confused. He presents no problems with his mood. Pt does not appear to be responding to internal stimuli. while pt can be irritable at times. he has not been known to pursue other pts. No medication changes were made for Resident #2.<br><br>Record review of Resident #1 and Resident #2 clinical records reflected both residents were seen by Psych services on 02/03/25 and medications were reviewed.<br><br>Record review of Safe surveys were completed with five residents with no issues noted.<br><br>Record review of Resident #1 and Resident #2 Behavior Monitoring Symptoms tasks were being completed.<br><br>Record review of Resident #2's clinical records reflected Resident #2 no longer resided in the memory care unit . Resident #2 was moved to another part of the facility when BIMS Score was reviewed on 03/27/25 and room was available on 04/02/25.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's In Service Training, dated 02/02/25, provided by the DON, reflected all facility staff were In Serviced on Resident to Resident education - Make sure that we are responding quickly and documenting any behavior escalations. Make sure the abuse prevention [coordinator] is notified or the back up and that all details of event are effectively communicated. MD and family to be notified of behaviors and an evaluation requested. 4. Notify provider if a resident is refusing medications/care. All behaviors must be care planned. Behaviors must be documented in the behavior monitoring forms .Abuse and Neglect - Please review the attached policy on abuse and neglect. You should be able to name the types of abuse and know what constitutes neglect. Types of abuse: verbal; physical; mental; sexual; involuntary seclusion; misappropriation of funds. Neglect: failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Abuse prevention Coordinator: [Administrator], Admin. Back up: [DON], RN .Please monitor your residents for sexual behaviors. If any behaviors are noted, please respond in a calm and respectful manner and separate the residents. Notify the nurse immediately. If you see a resident that is attempting to make sexual advances or comments, redirect them and notify the nurse. As the nurse you are to inform the family, physician and abuse prevention coordinator. Please review attached for managing sexual behaviors with dementia patients.<br><br>The noncompliance was identified as PNC. The noncompliance began on 02/02/25 and ended on 02/03/25. The facility had corrected the noncompliance before the survey began. |