

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, record reviews, and interviews the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 5 residents (Residents #1, #2, #3, #4, and #5) of 20 residents reviewed for accommodation of needs. The facility failed to ensure call lights were placed within reach of Residents #1, #2, #3, #4, and #5. This failures could place residents at risk of harm or inability to call for help. Observations on 7/10/25 from 11:03 AM-11:54 AM of the 300 and 400 Halls revealed call light cords were not within reach of Residents #1, #2, #3, #4, and #5. Resident #1's cord was stored in her bedside dresser. Resident #2's cord was under her mattress. Residents #3, #4, and #5's cords were hanging from the light above the head of the bed. All of the residents were in their beds, and their call lights were not within their reach. Follow up observations on 07/10/25 from 1:06 PM-1:24 PM of the 300 and 400 Halls revealed the call light cords remained in the same locations. Resident #1's cord was stored in her bedside dresser. Resident #2's cord was under her mattress. Residents #3, #4, and #5's cords were hanging from the light above the head of the bed. All of these call lights were not within reach of the residents. An interview was attempted on 07/10/25 at 11:03 AM with Resident #1; however, she did not respond when asked about her call light. In an interview on 07/10/25 at 11:06 AM, Resident #2 stated she was unable to locate her call light cord. The resident stated she was able to use her call light when needed, and it was not out of reach very often. An interview was attempted on 07/10/25 at 11:40 AM with Resident #3; however, the resident was non-responsive to questions. In an interview on 07/10/25 at 11:43 AM, Resident #4 stated she was unable to locate her call light cord. The resident stated she was able to use her call light when needed, and it was not out of reach very often. In an interview on 07/10/25 at 11:54 AM, Resident #5 stated she was unable to locate her call light cord. The resident stated she was able to use her call light when needed, and it was not out of reach very often. In an interview on 07/10/25 at 2:20 PM, RN A stated the call light cord needed to be within reach of the residents, so they could call for help if needed. He stated the risk of not having the call light within reach of the resident was the resident falling when trying to get up without assistance. In an interview on 07/10/25 at 2:23 PM, CNA B stated the residents' call lights had to be within reach of the residents, so they could call for help if needed. She stated she did not know why the call lights were not within reach of the residents. In an interview on 07/10/25 at 2:28 PM, LVN C stated call light cords had to be secured to the resident's bedding or the bed rail if they had one. She stated the call light needed to be within reach and easily located to prevent the resident from hurting themselves when trying to get out of bed and help themselves. She stated all staff were responsible for ensuring resident call lights were within reach of the residents. In an interview on 07/10/25 at 2:32 PM, LVN D stated resident call light cords had to be within reach of the resident. She stated if the call light was not where they could reach it, the resident would not be able to call for assistance and could fall or have an accident. In an interview on 07/10/25 at 2:35 PM, the DON stated call light cords should always be left within reach of the resident. She preferred the cord was secured to the bedding or the bed rail so it would not slide off. She stated the biggest risk to the residents was not being able to call for assistance. She stated it could cause the resident to try to get up and help themselves and fall in the process. Record review of the facility's Call Lights: Accessibility and Timely Response policy, dated 10/13/22, reflected: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance 5. Staff will ensure the call light is within reach of resident and secured as needed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents had the right to be free of abuse for 3 of 5 residents (Residents #6, #7 and #8) reviewed for abuse. The facility failed to ensure Residents #7 and #8 had the right to be free from abuse when Resident #6 hit Resident #7 in the face on 06/26/25 and put his hands around Resident #8's neck on 07/02/25. An IJ was identified on 07/10/25. The IJ began on 06/26/25 and was removed on 07/06/25. The facility took action to remove the IJ before the abbreviated survey began. While the IJ was removed on 07/06/25, the facility remained out of compliance with a scope of pattern and severity level of no actual harm with potential for more than minimal harm. The failure placed residents at risk for abuse. Findings included: Record review of Resident #6's admission MDS, dated [DATE] and signed as complete by the DON on 06/25/25, reflected the resident was a [AGE] year-old male. The resident admitted from home to the facility on [DATE], and his diagnoses included Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, and depression. The resident had severe cognitive impairment with a BIMS score of zero, and he displayed disorganized thinking and intention continuously. The resident was assessed to have physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, disruptive sounds), and wandering, which all occurred 1 to 3 days during the assessment period. These behaviors were assessed to significantly intrude on the privacy or activity of others. The MDS also reflected the resident rejected evaluation or care that was necessary to achieve the resident's goals for health and well-being, which occurred 1 to 3 days during the assessment period. The MDS further reflected the resident was able to transfer and walk independently. Record review of Resident #6's Care Plan, initiated on 06/13/25, reflected Resident #6 had the potential to be verbally and physically aggressive related to poor impulse control. The Care Plan included the following: Problem: 6/12/25 angry look in his face, threw coloring book across the table Problem: 6/14/25 climbed into bed with peer combative, hitting/swinging at staff during redirection. Intervention: 6/14/25 attempted to remove from peer's bed, left alone [due to] agitation Date Initiated: 06/16/2025 Problem: 6/21/25 entered female peer's room and began hitting and grabbing at the CNA's clothes when she attempted to redirect him out of room, attempted to hit female peer Intervention: 6/21/25 attempted to redirect from room, CNA used her body to shield female resident from both men, [Resident #6] left room [status post] incident with male peer, refused skin assessment and VS, NP notified with N.O. anxiolytic topically Q 6hrs, RP/DON/ADON/weekend supervisor notified, placed on 1:1 supervision; 6/22/25.NP N.O. anxiolytic PO Q6hrs PRN, RP notified - Date Initiated: 06/23/2025. Problem: 6/24/25 agitated, striking out at staff. Intervention: 6/24/25 PRN anxiolytic administered - Date Initiated: 06/25/2025. Problem: 6/26/25 hit peer in the face with closed fist. Intervention: 6/26/25 separated from peer and escorted to room, encouraged to sit on bed and provided with books to color, MD/NP/RP/DON/ADON/Administrator notified, unable to obtain VS d/t agitation, SW completed updated BIMS assessment with BIMS 1. Date Initiated: 06/27/2025 Problem: 6/27/25 combative with sitter and peers. Intervention: 6/27/25 staff attempted to redirect, once calmed down he walked to his room, PRN medication administered, DON notified, taken out on patio x approximately 15 minutes. Date Initiated: 06/30/2025. Problem: 6/30/25 verbal/physical aggression towards staff: swinging/kicking/hitting, throwing items in room, swinging pencil. Intervention: 6/29/25 verbally redirected, assisted to bed, covered with blanket, assessed as able without waking [Resident #6] up, continued monitoring. Date Initiated: 06/30/2025. Intervention: 6/30/25 topical anxiolytic applied with assistance, pencils removed and placed in med room, NP witnessed episode, continues 1:1 monitoring. Date Initiated: 07/01/2025 Problem: 7/1/25 threw chair at sitter, then charged sitter and fell, stood up and charged at sitter again, pacing. Intervention: 7/1/25 assessed, area treated, DON/ADON/MD/RP notified with N.O. transfer to hospital r/t injury, unable to obtain VS, patio door opened, and [Resident #1] came in facility, RP arrived at facility, transferred to hospital Problem: 7/2/25 kicked the table, entered peer's room and placed his hands around peer's neck. Intervention: 7/2/25 kicked table: assessed with trauma noted to R great toe, area cleansed and treated. 7/2/25 placed hands around peer's neck: separated from peer immediately, [head-to-toe assessment] completed, VS obtained, redirected, MD/RP notified; SWA sending clinicals to [Behavioral Health Hospitals]. Date Initiated:07/02/2025. The Care Plan also reflected the following additional interventions to address Resident #6's verbal and physical behavioral symptoms: Administer medications as</p>		