

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/16/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #1) reviewed for quality of care. -The facility failed to ensure Resident #1, who was diagnosed with congestive heart failure, had physician orders in place for fluid restrictions and daily weights. This failure could place residents at risk for worsening of condition, which could lead to serious harm. Findings included: Record review of Resident #1's Discharge MDS Assessment, dated 05/05/26, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE], readmitted on [DATE], and discharged on 05/05/26. The MDS Assessment under Section C-Cognitive Patterns reflected Resident #1's BIMS score was not documented. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 required moderate assistance with most self-care ADLs. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1's active diagnoses included: heart failure, chronic kidney disease, and unspecified dementia (brain disorder that causes loss of memory and thinking). Record review of Resident #1's Care Plan, revised 06/22/26, reflected Resident #1 required a structured environment on a secure unit r/t cognitive deficit. Interventions included: providing cues and reminders for ADLs and keeping a routine for bathing, dressing, and eating. The care plan also reflected Resident #1 had chest pain r/t angina (pain r/t to heart condition). Interventions included: giving nitroglycerin (medication used to treat chest pain) or other medication as ordered, identifying and documenting activities known to cause anginal pain, encouraging the resident to report pain, monitoring and documenting signs of edema (swelling of tissue), and monitoring vital signs during reported chest pain episodes. Record review of Resident #1's hospital records, dated 02/08/26, reflected in part the following: Chief complaint: Swelling and discoloration of the right foot and toe, and wheezing. Assessment and Plan: CHF exacerbation-Will admit inpatient-Cardiac monitoring-fluid restriction, daily weight and IV Lasix (water pill)-Cardiology consulted-[RP] will bring complete medication list from nursing home.[Resident #1] Discharge General Information Reason for visit: fluid overload. Discharge Instructions: Cardiac-fluid restrictions: limit 2000 mL/day Weight monitoring: daily. discharge date : [DATE]. Record review of Resident #1's progress notes, dated 02/18/26 at 5:17 p.m. by LVN C, reflected the following: [Resident #1] returned to facility via transport from [hospital] Today. [Resident #1] is A/O to person only. [Resident #1] vitals were taken upon arrival. 142/96 51, 18, 98% 97.4. Resident is currently on 2000ml per day fluid restriction intake. Family notified, Provider notified of return. Record review of Resident #1's progress notes, dated 02/09/26 at 8:14 a.m. by the ADON, reflected the following: [ADON] followed up with [RP] regarding [Resident #1] return to facility. [RP] stated that resident was admitted to [hospital] on Saturday due to low heart rate. no further concerns at this time. Record review of Resident #1's (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 07/16/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vitals (weights) in the EHR, from 02/18/26-05/05/26, reflected the following documented weights:-02/18/26-190.4 lbs.-02/19/26-190.4 lbs.-02/26/26-190.4 lbs.-03/03/26-187.8 lbs.-03/05/26-187.8 lbs.-04/01/26- 190.2 lbs.-05/01/26- 184.9 lbs. Record review of Resident #1's nurses' daily skilled notes, from 02/18/26-03/02/26, reflected the resident's weights were not assessed and documented daily. Further review of the resident's EHR reflected there were no documented daily skilled notes from 03/03/26-05/05/26. Record review of Resident #1's consolidated physician orders, dated 07/16/26, reflected the following:- Weigh weekly x 4 weeks, then monthly and PRN one time a day every 7 day(s). Start Date: 02/19/26Further review of this document reflected that the resident did not have orders for daily weights or fluid restrictions. In an attempted interview with Resident #1's RP on 07/16/26 at 10:35 a.m., the call was unsuccessful due to no response. Callback information was left on voicemail. In an interview on 07/16/26 at 11:38 a.m., the ADON stated Resident #1 was diagnosed with heart disease along with other comorbidities and was treated at the VA clinic. The ADON stated the facility coordinated Resident #1's care through a VA liaison. He stated Resident #1 was out on pass with the RP, then the RP reported that the resident had a change in condition and was admitted to the hospital on [DATE]. The ADON stated Resident #1 was discharged from the hospital on [DATE] and returned to the facility. The ADON was unaware that Resident #1 had a discharge order for fluid restrictions, but confirmed it after reviewing the hospital records. The ADON stated the expectation was for the receiving nurse to review discharge orders and notify the MD of any changes. The ADON stated all residents were weighed at least monthly unless otherwise ordered by the MD. However, the ADON stated the nurses completed daily skilled notes and were supposed to document a current weight. In an attempted interview with Resident #1's RP on 07/16/26 at 12:00 p.m., the call was unsuccessful due to no response. Callback information was left on voicemail. In an interview on 07/16/26 at 1:48 p.m., the MD stated Resident #1 had end-stage dementia and CHF, and it was important to monitor his fluid intake because his heart was unable to pump out excess fluids and daily weights could help monitor fluid retention. He stated not monitoring fluid intake and weights could place the resident at risk of increased heart and lung issues. The MD stated when a resident returned to the facility from the hospital, the expectation was for the nurses to notify him of any new orders. The MD stated Resident #1's RP would not always involve the facility in the care that Resident #1 was receiving from outside providers, and he did not believe the facility was responsible for any missed orders or appointments. In an interview on 07/16/26 at 2:03 p.m., LVN A stated she worked at the facility for 7 years and currently worked on the memory care unit. LVN A stated for safety reasons, staff kept pitchers of water out of the resident rooms and provided water as needed, so intake was monitored in general. However, LVN A stated an order was required for residents who were formally placed on fluid restrictions, and the nurses were responsible for ensuring that the order was carried out by tracking and documenting all fluid intake. LVN A stated all residents had monthly weights as a standard order, but some had a special order for weekly or daily weights. She stated that nurses also documented residents' most recent weights in their daily skilled notes. In an interview on 07/16/26 at 2:03 p.m., LVN B stated when a resident returned to the facility from the hospital, the nurses were responsible for reviewing the discharge summary to check for any new orders and any changes in behaviors and physical and mental health. LVN B stated any new orders had to be reported to the MD, who would likely agree and sign off, and the orders had to be updated into the system for everyone to be made aware. The facility's policies on physician orders and fluid restrictions were requested from the Administrator on 07/16/26 at 4:51 p.m. and they were not provided by exit. The Administrator stated the corporate resource was unable to find the specific policies.		