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	07/25/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review the facility failed to provide a private meeting space for the residents' monthly group meetings for 10 of 10 confidential residents reviewed for resident council. The facility failed to provide a private space for resident group meetings. This failure could place residents, who attended resident group meetings, at risk of not being able to voice concerns due to a lack of privacy. Findings included: Interview on 07/23/24 at 9:21 AM with the Activity Director revealed the resident group meetings were being held up stairs in the open middle area. Activity Director stated the only other space would be the conference room which was where the survey team was working. Observation and interview on 07/24/24 beginning at 10:30 AM, during a confidential resident group meeting with 10 residents, revealed the meeting was held in the activity/dining room. There were doors that closed off the space from one hall to another hall; however, in between the hall there was several offices to include the DON's office, the Social Worker's office, the HR office, and the Staffing Coordinator's office and several more along with the elevator and a large open area to the bottom floor. There were no signs posted to indicate that a confidential meeting was being held; however, multiple staff walked through the space to get from one hall to the next hall. The residents who were attending the resident council meeting stated they felt intimidated and uncomfortable having real discussions in the open area because staff might retaliate. Residents Interview on 07/25/24 at 4:24 PM with the Activity Director revealed she had been employed at the facility for [AGE] years. He stated he was responsible for organizing the resident council meetings. She stated resident group meetings were held on the last Tuesday of every month. The Activity Director stated the resident group meetings were always held in the open middle dining area. She stated she knew the meetings were confidential and had to be held in a private space. The Activity Director stated they started having the resident group meetings in the open space upstairs because it was difficult for the last Resident meeting President to fit through the doors of the conference room. The Activity Staff stated the risk of not holding resident group meetings in a private space was the residents not feeling comfortable talking about their concerns and fearing that staff would hear them. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/25/24 at 6:58 PM with the Administrator revealed the resident group meetings were held in the conference room. He stated normally 10 to 12 residents would usually attend resident group meetings. He stated they had limited spaces in the facility, that the meetings being held in the middle space upstairs was temporary to accommodate all residents and their mobility devices. He stated he had not had any residents complain to him about resident group meetings not being in a private area. The Administrator stated his expectation was for the meetings to be held in a private space for the residents to voice their concerns openly. Record review of the resident council minutes revealed no requests for a private area. The facility was asked to provide policies regarding resident rights, privacy, resident council however the policy was not provided by exit.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on interview and record review, the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of changes for those services, which included changes for services not covered under Medicare/Medicaid or by the facility's per diem rate for 1 of 3 residents (Resident #89) reviewed for Medicare/Medicaid coverage. The facility failed to ensure Resident #89 was given a SNFABN (SNFABN document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility prior to covered days being exhausted. This failure could place residents at risk for not being aware of changes to provided services. Findings included: Record review of Resident #89's face sheet dated 07/25/2024, indicated a [AGE] year-old male, originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included displaced fracture of olecranon process without intraarticular extension of left ulna (a break in the bony prominence at the back of the elbow joint), Fracture of unspecified part of neck of right femur (thigh bone is the only bone in the thigh, lower limb between the hip and the knee), fusion of spine, lumbar region (surgery that joins two or more vertebrae), general muscle weakness. Record review of admission MDS assessment dated [DATE], indicated Resident #89 had the ability to make himself understood and understood others. The assessment indicated Resident #89's BIMS score was 10, which indicated his cognition was moderately impaired. The assessment indicated Resident #89 was receiving occupational and physical therapy. Record review of the SNF Beneficiary Protection Notification Review indicated Resident #89 was receiving Medicare Part A services starting on 03/15/2024 and the last covered day of Part A services was 05/22/2024, however a SNF ABN was not completed which would have informed Resident #89 of the option to continue services at the risk of out of pocket cost. During an interview on 07/25/24 at 3:05 PM, MDS Coordinator A stated she was responsible for ensuring Resident #89 was issued a SNF ABN. MDS Coordinator A stated the form should have been issued if the resident had skilled benefit days remaining and was being discharged from Part A services and continued living in the facility. When asked why the form was not given, MDS Coordinator A stated, she was not trained to provide the letter by the previous MDS Coordinator, however, was fully aware of the process at this time. MDS Coordinator A stated it was important to ensure residents received the form because it notified the family and resident that there was a possibility that they could be responsible for extra charges that the insurance would not cover. MDS Coordinator A stated risk included residents would not get additional services as they wished. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/24 at 7:26 PM, the Administrator stated the MDS Coordinators were responsible for ensuring the SNF ABN was completed. The Administrator stated the regional coordinator was responsible for monitoring and overseeing. The Administrator stated it was important for residents to receive the SNF ABN so they are aware of how many days they have left that the insurance will pay when receiving services. Record review of the facility's' undated policy, titled Regency Integrated Health Services, LLC, indicated, A SNF must advise the beneficiary, orally and in writing, before the extended care item or service is initiated or continued that, in the SNF's opinion, the beneficiary will be fully and personally responsible for payment for the specified extended care item or service that it furnishes. Record review of an undated document titled The Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) - Form CMS-10055, a CMS approved written notice that the Skilled Nursing Facility (SNF) gives to a Medicare beneficiary, or to his authorized representative, before extended care services or items are furnished, reduced, or terminated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on interview, and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 5 residents (Resident #9) reviewed for MDS assessment accuracy. The facility inaccurately coded Resident # 9's quarterly MDS assessment dated [DATE] for dialysis treatment when she was not receiving dialysis treatment. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Review of Resident #9's face sheet dated [DATE] indicated Resident #9 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #9 had a diagnosis of chronic kidney disease, stage 4 (severe loss of kidney function), and kidney transplant status (surgery to place a healthy kidney from a living or deceased donor into a person whose kidneys no longer function properly). Review of Resident #9's admission MDS dated [DATE] revealed Resident # 9 had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS Assessment for Resident # 9 section O revealed Special Treatment for Dialysis. Review of Resident #9's care plan, dated [DATE], did not reflect any dialysis treatments. Review of Resident #9's physician orders revealed no orders for dialysis treatments. Interview on [DATE] at 11:10AM, Resident #9 revealed she was not a dialysis patient. Resident #9 stated she stopped receiving dialysis 3 years ago after she got a kidney transplant. Interview on [DATE] at 10:07 AM, the MDS Coordinator revealed she had been employed for one year. She stated it was the MDS Coordinator's responsibility to complete the MDS assessments. The MDS Coordinator stated she was not responsible of Resident #9 MDS assessment, but another MDS nurse was but she does not work anymore for the facility. She stated she had not realized there was an error on her MDS, but since she had been noted she will rectify. She stated on the resident's MDS they trigger any special treatment the resident was receiving. The MDS Coordinator reviewed Resident #9's clinical records and stated she was not a dialysis patient. The MDS Coordinator stated it was the MDS Coordinator's responsibility to complete the assessments correctly and indicate whether she was receiving dialysis or not. She stated the risk of not completing MDS assessments correctly could cause residents to receive the wrong care. Interview on [DATE] at 06:50 PM, the acting DON revealed the MDS Coordinator was responsible for completing MDS assessments. The DON stated she was the acting DON only, and she does not know the resident. Review of facility policy Assessment Frequency/Timeliness dated [DATE], reflected the following: The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The comprehensive admission assessment will be completed within 14 days after admission, excluding readmissions in which there is no significant change, an admission assessment was completed during the prior stay, the resident was discharged return anticipated and the resident returned within 30 days as described per the RAI Manual instructions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #136 and Resident #103) of 7 residents reviewed for comprehensive care plans. The facility failed to update Resident #136's care plan to address dialysis. The facility failed to update Resident #103's care plan to address fecal impaction (constipation). This failure could place residents at risk of not having their individual needs met, not receiving necessary care and services, and a decreased quality of life. Findings included: 1. Record review of Resident #136's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #136's admission MDS assessment, dated 07/09/24, reflected a BIMS score of 06, which indicated severe cognitive impairment. Her diagnoses included chronic kidney disease, stage 3, dependence on renal dialysis. The MDS further revealed Section O - Special Treatments, Procedures, and Programs indicated resident was receiving dialysis. Record review of Resident #136's care plan revised date 04/22/24 indicated dialysis was not cared plan. Record review of Resident #136's physician order dated 03/30/24 revealed Dialysis provided by [Dialysis Name] locate at [address] Dialysis days are Tuesday-Thursday-Saturday at 7:15 am Days may vary based on holidays and dialysis center schedule. Record review of Resident #136's physician order dated 03/30/24, revealed Permcath right chest: Monitor for signs and symptoms of infection or bleeding. Notify MD. every shift. Interview on 07/23/24 at 4:16 PM, Resident #136 revealed she was doing well. Resident #136 stated she was a dialysis patient. Resident #136 stated she goes to dialysis Tuesdays, Thursdays, and Saturday. Resident #136 stated she could not recall if she was given any communication forms to take to dialysis. Resident #136 denied any discomfort or pain to her port site. 2. Record review of Resident #103's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #103's quarterly MDS assessment, dated 07/15/24, reflected his diagnoses included unspecified sequelae of cerebral infarction (stroke), hypertension and dysphagia (difficulty swallowing). Resident #103 BIMS score was not completed due to resident being rarely/never understood. MDS further revealed Section GG - Functional Abilities and Goals indicated resident was totally depended on staff for toileting. Section H - Bladder and Bowel indicated Resident #103 was always incontinent for urinary and [NAME] continence. Record review of Resident #103's care plan, revised on 12/06/23, reflected: Focus: [Resident #103] has bladder and bowel incontinence. Goal: [Resident #103] will remain free from skin breakdown due to incontinence and brief use through the review date. [Interventions: [Resident #103] Monitor and document intake and output. Monitor/document/report PRN any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects. Care plan does not address fecal impaction after hospital visit on 07/14/24. Record review of Resident #103's Hospital Discharge Summary, dated 07/14/24, reflected Massive amount of stool in the rectum consistent with fecal impaction. No bowel obstruction. Observation on 07/23/24 at 4:32 PM, Resident #103 was in bed watching television. Resident #103 was unable to carry out a conversation. No signs of discomfort or pain noted. Interview on 07/25/24 at 1:22 PM, ADON C revealed she was the ADON assigned to Resident #136 and Resident #103. She stated Resident #136 was a dialysis patient and it should be care planned. ADON C reviewed Resident #136's care planned and stated it was not care planned. ADON C stated Resident #103's fecal impaction should had been care planned. She stated it was the responsibility of the MDS Coordinator to create and update care plans. She stated it was probably missed. Interview on 07/25/24 at 3:10 PM, the MDS Coordinator revealed the MDS Coordinators was responsible for creating and updating care plans. She stated long-term, short-term, and skilled have their own MDS Coordinators. MDS Coordinator reviewed Residents #136's care plan and stated resident was not cared planned for dialysis. She stated she should had been care planned for dialysis. MDS Coordinator stated Resident #103's fecal impaction should have been care planned. She stated it should have its own concern areas to address the fecal impaction. She stated the MDS Coordinator who was assigned to Resident #136 and Resident #103 was currently on leave. The MDS Coordinator stated MDS are reviewed quarterly, and the DON was responsible for reviewing them. Potential risk of care plans not being updated could lead into care areas being missed like dialysis or reoccurring constipation. Interview on 07/25/24 at 6:04 PM, the Acting DON revealed her expectations are for care plans to be updated. She stated the MDS Coordinators were responsible for completing the comprehensive care plans and to be reviewed quarterly. She stated it was the DON responsibility to ensure care plans are completed and updated. Record review of the facility's policy titled Comprehensive Care Plans dated 10/24/22, reflected the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or d. The resident's goals for admission, desired outcomes, and preferences for future discharge. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 44937 48236 Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 4 of 6 residents (Residents #334, #386, #88 and #109) reviewed for ADLs. 1.The facility failed to ensure Resident #334 received showers as scheduled. 2. The facility failed to ensure Resident #386 received showers as scheduled. 3. The facility failed to provide Resident #88 assistance with daily oral care. 4. The facility failed to provide Resident #109 assistance with daily oral care. These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. The findings include: 1.Review of Resident #334's face sheet, dated 07/25/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Review of Resident #334's admission MDS Assessment, dated 07/19/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnosis included unspecified osteoarthritis, other osteoporosis without current pathological fracture, unsteadiness on feet acute pain due to trauma and muscle wasting and atrophy. MDS further review reflected Resident #334 was dependent on staff regarding bathing. Review of Resident #334's Initial Baseline/Advance Care Plan, dated 07/15/24, reflected Resident required assistance with ADLs. Problem: The resident has an ADL self-care performance deficit r/t. Interventions: Bathing/Showering. Review of Resident #334's POC Response History for July 2024 reflected the following under Task - ADL-Bathing revealed no showers or bed baths provided since being admitted on [DATE]. No indications of refusals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/23/24 at 3:03 PM, Resident #334 was lying in bed watching television. Resident #334 appeared clean and well-groomed. Resident #334 stated he admitted to the facility 07/15/24 and he had not received a shower. Resident #334 revealed his shower days were Tuesday, Thursdays, and Saturdays. Resident #334 stated he had not been offered a shower and he had requested to get a shower; however, he had not received it. Resident #334 could not recall the name of the staff who he had told. Resident #334 stated he felt dirty and would like to feel clean. Resident #334 denied any skin breakdowns. Interview on 07/24/24 at 5:08 PM, Nurse Aide N revealed she was the staff assigned to Resident #334. Nurse Aide stated Resident #334 should had received a shower yesterday 07/23/24 and his next shower would be Thursday 07/25/24. She stated even room number showers were provided Monday, Wednesdays, and Fridays for A bed during 6AM-2PM and B bed during 2PM-10PM, and odd room number showers were provided Tuesday, Thursdays and Fridays for A bed during 6AM-2PM and B bed during 2PM-10PM. Nurse Aide N stated she was not sure if Resident #334 received a shower yesterday (7/23/24). Nurse Aide N reviewed Resident #334 POC and stated based on the documentation it showed resident was not provided with a shower and there was no documentation of refusal. Interview on 07/24/24 at 5:43 PM, RN M revealed she was the nurse assigned to Resident #334. She stated CNAs were responsible for providing showers to residents on their shower days. She stated she observed Resident #334 receive a bed bath but could not recall the day. She stated Resident #334 refuses his showers because of his hip fracture resident does not want to get up from his bed. RN M stated based on the documentation it shows that Resident #334 had not received a shower. RN M stated if residents did not receive their showers or baths like they were supposed to, it could lead to them developing skin breakdowns. Follow up interview on 07/24/24 at 5:50 PM, Resident #334 stated he had not received a bed bath. Resident #334 stated staff came in his room and told him that he had received a bed bath but he was sure he did not. Resident #334 then stated [I] might not remember what happened a year ago but [I] do remember what happened in the last week. Resident #334 stated he was told he would receive a shower today (07/24/24). Interview on 07/25/24 at 2:00 PM, the ADON revealed her expectations are for residents to be given their showers and for staff to document in the POC. She stated if a resident refuses a shower, it was the CNAs responsibility to document and report to the nurse and it was the nurse responsibility to follow up with the resident. She stated if residents did not receive their showers or bed baths like they were supposed to, it could lead to them developing skin breakdowns and infections. Interview on 07/25/24 at 6:10 PM, the Acting DON revealed her expectations are for staff to provide residents with showers on their shower days and to document if showers were provided or refused. She stated CNAs should offer showers and if the resident refuses after the third attempt the nurses should follow up and then document. She stated the potential risk of showers not being provided would be skin integrity and resident rights. 2. Record review of Resident #386's face sheet, dated 07/25/2024, indicated Resident #386 was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #386's admission MDS assessment, dated 06/22/2024, indicated Resident #386 had the ability to make himself understood and understood others. The assessment indicated Resident #386's BIMS score was 12, which indicated his cognition was intact. Resident assessment also indicated partial/moderate assistance with eating and oral hygiene, substantial/maximum assistance with shower/bathing, personal hygiene, and upper body dressing. Resident #386 was dependent on staff with toileting, lower body dressing, and footwear. Record review of Resident #386 care plan, undated, indicated Resident #386 had an ADL self-care performance deficit related to impaired mobility. Goal: Resident #386 will maintain current level of function in ADLs. Interventions included: Functional Performance: Resident #386 required partial/moderate assistance with Oral Hygiene, substantial/maximum assistance with one staff to Shower/Bathe Self and Personal Hygiene, dependent on staff with Toilet Hygiene and Tub/Shower transfer. When bathing/showering: check nail length and trim and clean on bath day and as necessary. Record review of Resident #386's task for ADL care revealed from 07/19/24 - 07/25/24 Resident #386 had indicated last bath/shower was 07/20/24. Observation and interview on 07/23/24 at 11:29 AM, with Resident #386 revealed him in bed, hair oily and in disarray, facial hair grown out, nails were long with dark substance underneath nails. According to Resident #386 he was waiting to receive a shower. Resident #386 stated he was looking forward to a shower to have a shave, he stated his facial hair was longer than he preferred and was growing underneath his neck area. Resident #386 stated he did not know what the substance was underneath his nails but would like to have them trimmed. Observation and interview on 07/24/24 at 5:25 PM, ADON C revealed Resident #386 had not received a bath, shower shave or nail care. ADON C spoke with Resident #386 and ensured he would receive a shower today and apologized for the delay. According to ADON C aides were responsible for ensuring Resident #386 received a shower or bath along with nail care and a shave if he wanted. According to ADON C not providing ADL care to residents placed them at risk of infections and having dignity issues. ADON C stated she expected aides and nursing staff to ensure residents were having their showers/baths on their scheduled days, if not report any refusals or missed opportunities. ADON C stated charge nurses and herself were responsible to ensure aides were providing adequate ADL care. Observation of Resident #386 on 07/25/24 at 8:18 AM, revealed Resident #386 was in bed with same bedding and clothing as the previous days indicating he had not had a shower or bath. Resident #386 had a partial shave leaving patches of missed hair on his face, Resident #386 still had grown hair under his neck about an inch long. Resident's nails were still long with substance underneath. 3. Record review of Resident #88's face sheet, dated 07/25/2024, indicated Resident #88 was a [AGE] year-old female, admitted to the facility on [DATE]. Record review of Resident #88's admission MDS assessment, dated 06/29/2024, indicated Resident #88 had the ability to make herself understood and understood others. The assessment indicated Resident #88's BIMS score was 15, which indicated her cognition was intact. Resident assessment also indicated extensive assistance with two or more persons with bed mobility and toileting, Supervision with eating by one person. Resident #88's diagnosis included chronic obstructive pulmonary disease, chronic respiratory failure, morbid (severe) obesity, essential hypertension (high blood pressure), heart failure. (continued on next page)

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	675622	A. Building B. Wing	07/25/2024

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #88's care plan, undated, indicated Resident #88 has an ADL self-care performance deficit related to impaired mobility, obesity. Goal: Resident #88 will maintain current level of function in ADLs. Interventions included: Functional Performance: Resident #88 required dependent assistance by one staff for Oral Hygiene, Personal Hygiene, Toilet Hygiene, Tub/Shower transfer, Shower/Bathe Self. When bathing/showering: check nail length and trim and clean on bath day and as necessary. Record review of Resident #88's task for ADL care revealed from 07/11/24 - 07/24/24 Resident #88 had taken a bed bath on 07/15/24 and 07/19/24, all other dates were indicated as not applicable. Observation and interview on 07/23/24 at 3:35 PM, revealed Resident #88 had long nails with brown, red, and white substance underneath nails on both hands, hair was greasy/oily with appearance that it had not been combed over days. Resident #88 had facial hair growing around her upper lip and chin area. According to Resident #88 her nails were longer than she particularly liked, Resident stated she did not know what the substance was underneath her nails. Resident stated staff had never cut or trimmed her nails and had not ever asked her about the length. Resident #88 stated she went to dialysis three days a week and sometimes would get a wipe down before leaving but could not say when the last time she had a shower or bed bath. Resident #88 stated she did not know she had facial hair, no one had mentioned it and stated she rather not have facial hair. Resident #88 stated she hardly had her washed or combed. Observation and interview on 07/25/24 at 8:51 AM, LVN H revealed Resident #386, LVN H stated it appeared resident had not had a shower, LVN H stated it appeared someone attempted to shave him however it was hit and miss with the shave. Observation of Resident #88 revealed she had dirty long nails and hospital gown with stains, when asked about a shower, Resident #88 stated staff had not attempted to provide a shower or bath for her. LVN H stated aides were responsible for ensuring showers were completed on shower days which included hair, nails, and a shave. LVN H stated not providing proper hygiene placed residents at risk for infection, disease, and skin damage. 4. Record review of Resident #109's electronic face sheet, dated 07/25/24, revealed an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #109 had diagnoses which included senile degeneration of the brain, unspecified dementia, need for assistance for with personal care, and adjustment disorder with depressed mood. Record review of Resident #109's Comprehensive MDS assessment, dated 06/19/24, revealed Resident #109 had a BIMS score of 4, which indicated her cognition was severely impaired. Further review revealed section GG 5. B. Oral Hygiene indicated code 2 (substantial/maximal assistance), which meant Helper does more than half the effort; Helper lifts or hold the trunk or limbs and provides more than half the effort. Record review of Resident #109's care plan, dated 07/25/24, revealed Resident #109 required substantial/maximal assistance from staff for oral hygiene from staff. Resident #109 is encouraged to participate to the fullest extent possible with each interaction. Record review of Resident #109's orders, dated 07/25/2024, revealed no dental consult order for Resident #109 since admitted . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/23/24 at 12:11 PM, revealed that Resident #109 had extremely bad breath and it did not appear that her teeth had been brushed. Her teeth had white buildup that was along the top of her top teeth and the bottom of her bottom teeth. Observation on 07/25/24 at 12:26 PM, revealed Resident #109 had extremely bad breath and it did not appear that her teeth had been brushed. Her teeth had white buildup that was along the top of her top teeth and the bottom of her bottom teeth on them and food throughout the teeth. Resident #109 did not appear to wear dentures. Resident #109 also appeared to be missing several teeth including one on the bottom and one on the top in the front. Interview on 07/23/24 at 12:15 PM, with Resident #109 revealed that she was unsure if her teeth had been brushed. Interview on 07/23/24 at 2:41 PM, CNA E stated that brushing the resident's teeth is part of the daily skills for the resident. CNA E also stated that Resident #109 had two loose teeth and will not allow her to come close to the two teeth and therefore can't brush her teeth. CNA E confirmed that it is important to brush the residents' teeth as part of their morning grooming because it affects their health. CNA E also stated that the resident can be at risk for gingivitis. Interview on 07/25/24 at 02:41 PM, LVN F revealed that CNAs are supposed to brush the residents' teeth in the morning and the evening. However, LVN F stated that she is not in the room when it occurs. LVN F also revealed that a resident has the right to refuse oral care. LVN F said Resident #109 overall predominantly accepts oral care most of the time. LVN F continued by stating that she was unaware if the white build-up comes off Resident #109's teeth. And, LVN F said that the risk to oral care is infection, gum disease, rotten teeth, appetite changing, and physical decline. Interview on 07/25/24 at 02:58 PM, ADON A revealed that CNAs are supposed to perform oral care in the morning. ADON A also revealed that the resident is at risk for bad breath, infection, dental cavities, and a decline in health. Interview on 07/25/24 at 05:06 PM, the SS Director revealed that nurses do not automatically put a resident on the list for dental services. The SS Director stated that residents are asked quarterly if they want to receive services. The SS Director also added that she would call Resident #109's family to get permission to send the referral to the dental company so that the resident can be placed on the list to be seen by a dentist. She also revealed that the importance of being seen by a dentist is so that the resident will maintain good oral hygiene. The SS Director stated that if the resident does not have good oral hygiene, it can lead the resident to not eating, bacteria, etc. Interview on 07/25/24 at 06:56 PM, the Acting DON revealed that CNAs are supposed to offer oral care. The Acting DON stated that if the resident does not receive proper oral care both by a dentist and daily brushing, there is a risk for infection and a risk for nutritional decline. This will result in an overall health decline for the resident. Review of the facility policy Activities of Daily Living (ADLs) dated 05/26/23, reflected the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. 2. The facility may provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to ensure a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections based on the resident's comprehensive assessment for 1 of 3 residents (Residents #71) reviewed for urine incontinence/catheters. The facility failed to ensure Resident #71' catheter urine collection bag was kept off the floor and had a privacy cover. This failure could place residents with catheters at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Findings included: Review of Resident #71's Admission Record dated 07/24/24 reflected Resident was a [AGE] year-old male, admitted to the facility on [DATE]. Review of Resident #71's MDS assessment, dated 06/28/24, reflected the resident had severe cognitive impairment with a BIMS score was 8, and he required partial/moderate assistance with toileting. Resident #71's diagnoses included Urinary Tract Infections, Hypertension (high blood pressure), Heart Failure (impairment in the heart's ability to fill with and pump blood), coronary artery disease (reduction of blood flow to the cardiac muscle due to build up of plaque). Review of Resident #71's current, undated care plan reflected the resident had an indwelling catheter. Goal: resident will show no signs or symptoms of Urinary infection. Interventions included: Catheter: resident has 16F with 10ml bulb Foley catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Check for kinks as indicated and as necessary each shift. Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to doctor for any signs of Urinary Tract Infections. Review of Resident #71's order summary report reflected the following catheter orders: 03/25/24 - Change 16 Foley with 10 ml bulb as needed for Foley catheter. Observation and interview on 07/23/24 at 11:04 AM, Resident #71's catheter bag was laying on the floor on the side of the bed without a privacy bag. Resident #71 revealed at times he can feel the catheter pulling but could not tell if the bag was ever on the floor. Resident #71 stated he did not know his catheter bag did not have a privacy bag, however he would constantly request for staff to have his privacy curtain pulled as much as possible so he would have privacy from his roommate and the door being opened. Resident #71 stated he felt uncomfortable with his catheter revealing the contents of his urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/24/24 at 5:05 PM, revealed CNA G entered Resident #71's room to observe catheter bag. CNA G stated she did not work with Resident #71 on 07/23/24, however when she arrived on 07/24/24 she observed him without a privacy bag on his catheter. CNA G stated she then retrieved a privacy bag at that time to provide him with privacy and dignity. CNA G stated she was aware catheter bags should hang at appropriate levels not to touch the floor to prevent infections. CNA G stated aides were responsible to ensure bags were not on the floor and had a privacy bag, however all nursing staff could complete the task. Interview on 07/25/24 at 10:46 AM, LVN H revealed he was not aware of Resident #71's catheter bag on the floor, and it did not have a privacy bag. LVN H stated he usually worked weekends, however, LVN H stated Resident #71 should have had a privacy bag not doing so exposed him to dignity issues. LVN H stated aides were responsible to ensure privacy bags were administered. LVN H stated having catheter bag touching the floor placed Resident #71 at risk of infections. LVN H stated aides usually work with residents to empty the urine from the bags so they would best know where to hang the bag so that it was not pulling, kinked, or touching the floor. LVN H stated all nursing staff would be responsible to ensure catheters were off the floor and covered with privacy bag. Interview on 07/25/24 at 4:55 PM with ADON C revealed she was not aware Resident #71 was without a privacy bag and that his bag was touching the floor. ADON C stated resident catheter bags should not be on the floor but hung low to allow for gravity to work, not doing so placed residents at risk of infection and bacteria. ADON C stated catheter bags should be covered at all times for privacy. ADON C stated aides and nursing staff were responsible to ensure bags were covered and not on the floor at all times. Interview on 07/25/24 at 6:00 PM with DON revealed she was notified by the ADON C that Resident #71's catheter was found without a privacy bag and was on the floor. The DON stated all catheter bags were to be covered with a privacy bag to protect resident privacy and dignity. The DON stated her expectation was for all nursing staff to ensure catheter bags were covered and hanging properly to allow the fluid to drain properly and prevent possible infection and leaking. The facility was asked to provide a policy regarding indwelling Foley catheter care, resident rights and the DON stated they did not have requested policies.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received appropriate treatment and services to prevent complications for one (Resident #103) of three residents reviewed for gastrostomy tubes. LVN L failed to flush Resident #103's g-tube with 30ml of water before and after medication administration and provide 100 ml before and after his bolus feeding (feeding method using a syringe to deliver formula through feeding tube) as ordered by the physician. This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care. Findings included: Record review of Resident #103's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #103's quarterly MDS assessment, dated 07/15/24, reflected his diagnoses included unspecified sequelae of cerebral infarction (stroke), hypertension and dysphagia (difficulty swallowing). Resident #103 BIMS score was not completed due to resident being rarely/never understood. The MDS further revealed Section K - Nutritional Approaches was a feeding tube. Record review of Resident #103's care plan, revised on 04/12/24, reflected: Focus: [Resident #103] requires tube feeding r/t dysphagia. Goal: [Resident #103] will remain free of side effects or complications related to tube feeding through review date. [Resident #103] will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions: [Resident #103] is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Record review of Resident #103's physician order, dated 07/15/24, reflected Enteral Feed Order every shift Flush feeding tube with (30ml) of water before and after medication administration. Record review of Resident #103's physician order, dated 07/24/24, reflected Enteral Feed order six times a day free water 100 ml before and after each bolus. Observation on 07/25/24 at 8:24 AM, revealed LVN L preparing to provide Resident #103 medications and bolus feeding. LVN L checked Resident #103's g-tube placement and then checked for residual. LVN L flushed the g-tube with 30ml of water then proceeded to provide Resident #103 liquid medication of Lactulose, Levetiracetam and then Senna. LVN L did not flush between the liquid medications. LVN L then proceeded to provide Resident #103's bolus feeding and then flushed with 30ml of water. LVN L did not provide Resident #103 with 100ml of free water before or after bolus feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/25/24 at 9:53 AM, LVN L stated she was the nurse assigned to Resident #103. LVN L stated the procedure before providing a resident with medication and bolus feeding, they need to check for placement, and residual. She stated they flush 30ml before and after each medication and before and after bolus feeding depending on the physician order. LVN L reviewed Resident #103's physician orders and stated she did not provide Resident #103 with 30ml of water before and after his liquid medications. She stated since the medication was liquid, she thought she did not need to provide the 30ml of water. She stated she also forgot to provide resident with his 100ml of water before and after his bolus feeding. She stated since the stool softer was diluted with water she did not need to provide more water. LVN L stated she was in serviced on g-tube feeding yesterday 07/24/24. She stated the risk for not following physician orders could cause dehydration. Interview on 07/25/24 at 5:02 PM, ADON C revealed her expectations are for staff to follow physician orders. ADON C stated nurses should flush with 30ml of water before and after each medication. She stated depending on the physician order nurses should provide free water before and after each bolus feeding. ADON C stated all nursing staff was in serviced on g-tubes yesterday 07/24/24. She stated the risk of not following physician orders could cause dehydration. Interview on 07/25/24 at 6:13 PM, the Acting DON revealed her expectations are for nursing staff to follow physician orders when it comes to flushing. She said nurses should flush before and after each medication and before and after each bolus feeding. She stated the risk of not following physician orders could cause tubes to clog and dehydration. Record review of the facility's policy titled Enteral Tube Medication Administration dated 10/01/19, reflected the following: The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian, and consultant pharmacist . 6. Check the medication administration record (MAR) to confirm the order: note the medication, dose, route (tube), and volume of water for flushing. 7. Prepare medications for administration A. NOTE: Medication administration via tube requires flushing with water at several steps in the procedure. The total volume of water used for flushing should be included in the total amount allowed per day for fluid-restricted residents . D. Dilute liquid medications with 10-30mL (30mL may be needed if liquid is viscous) of warm water or enteral formula (if the liquid medication is hyperosmolar and compatible with enteral formulas) . O. Flush tubing with 15-30mL of water, or prescribed amount. If administering more than one medication, flush with 5mL of water, or prescribed amount, between each medication, or per physician's orders. Allow water to remain in tubing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 2 (Resident #32 and Resident #88) of 6 residents reviewed for respiratory care, in that: The facility failed to obtain physician orders for Resident #32 and Resident #88 to receive oxygen. The facility failed to replace Resident #32's oxygen humidifier bottle when empty. The facility failed to replace Resident #88's nasal cannula when it was discolored and it was not dated. This deficient practice could affect resident who received oxygen therapy continuously placed him at-risk for respiratory infection, and ineffective treatment. Findings included: 1. Record review of Resident #32's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #32's quarterly MDS assessment, dated 05/02/24, reflected her had a BIMS score of 02 which indicated cognition was severely impairment. Her diagnoses included obstructive uropathy, unspecified severe protein-calorie malnutrition, unspecified dementia, and essential hypertension (high blood pressure). MDS further revealed Section O - Special Treatments, Procedures, and Programs indicated resident received oxygen therapy. Record review of Resident #32's care plan, revised on 05/16/24, reflected: Problem: [Resident #32] has altered respiratory status/difficulty breathing r/t SOB. Goal: [Resident #32] will have no s/sx of poor oxygen absorption through the review date. Interventions: OXYGEN SETTINGS: O2 via NC PRN. Record review of Resident #32's physician orders dated 01/27/24 revealed Check O2 saturation every shift. Resident #32 did not have any orders for oxygen. Record review of Resident #32's July 2024 MAR revealed Resident #32's O2 sats are within normal limits. Observation on 07/23/24 at 12:43 PM, revealed Resident #32 laying in her bed, she stated she was doing well. Resident #32 was observed to have her oxygen on via nasal cannula . The oxygen concentrator was set at 2 liters, the oxygen concentrator humidifier bottle was dated 06/18/24 and was empty. Resident #32 stated she had always received oxygen. Resident #32 could not recall when the last time the tubing or water bottle was last changed. Resident #32 denied any discomfort or pain. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/24/24 at 3:29 PM, revealed Resident #32 lying in bed and had her oxygen nasal cannula on. Resident #32 her oxygen water had not been changed or tubing. She denied any discomfort. Interview on 07/24/24 at 3:34 PM, with LVN L revealed she was the nurse assigned to Resident #32. She stated Resident #32 had PRN oxygen orders. She stated she checked Resident #32's concentrator this morning (07/24/24) and noticed the water bottle was empty. She stated she was going to change the water bottle but not had the opportunity to do it. LVN L reviewed Resident #32's physician order and stated resident did not have orders for oxygen, and she was not aware she did not have orders. LVN L stated the nasal cannula should be changed every 7 days and oxygen concentrator as needed. LVN L then stated Resident #32 oxygen had been good within normal limits and she removed the nasal cannula from resident this morning (07/24/24); however Resident #32 puts it back on. While interviewing LVN L, the ADON C stated Resident #32 had standing orders for oxygen; however, when she reviewed the standing orders, she stated they did not have any for Resident #32 and needed to update the standing orders. LVN L stated Resident #32 should have orders for oxygen. LVN L stated they needed physician orders for anything they provide the resident with. 2. Record review of Resident #88's face sheet, dated 07/25/2024, indicated Resident #88 was a [AGE] year-old female, admitted to the facility on [DATE] Record review of admission MDS assessment, dated 06/29/2024, indicated Resident #88 had the ability to make herself understood and understood others. The assessment indicated Resident #88's BIMS score was 15, which indicated her cognition was intact. The assessment indicated Resident #88 had shortness of breath or trouble breathing while lying flat and required oxygen use before and during her stay. Resident assessment also indicated extensive assistance with two or more persons with bed mobility and toileting, Supervision with eating by one person. Resident #88's diagnosis included chronic obstructive pulmonary disease, chronic respiratory failure, morbid (severe) obesity, essential hypertension (high blood pressure), heart failure. Record review of Resident #88's care plan, undated, indicated resident has altered cardiovascular status related to hypertensive CKD, HTN , chronic systolic and diastolic congestive heart failure chronic A-Fib. Goal: Resident will be free from complication of cardiac problems. Interventions included assess for shortness of breath, oxygen via nasal canula settings 2 liters per minute. Resident has altered respiratory status/difficulty breathing related to chronic obstructive pulmonary disease, chronic respiratory failure, congested heart failure, oxygen dependence. Goal: Resident will have no signs or symptoms of poor oxygen absorption. Interventions: Elevate head of bed to promote optimal lung expansion, monitor/document changes in orientation, increased restlessness, anxiety, and air hunger, monitor for signs of respiratory distress and report to doctor, monitor abnormal breathing patterns and report to doctor, oxygen settings: oxygen via nasal canula at 2 liters per minute. Record review of Resident #88's physician order summary report, dated 07/25/24, did not indicate an active physician's order for oxygen use. (continued on next page)

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	675622	A. Building B. Wing	07/25/2024

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/23/24 at 12:13 PM, revealed Resident #88 with a nasal canula that was discolored and was not dated. Observation of the humidifier bottle revealed a date of 07/20/24. Oxygen level indicated Resident #88 was provided with 3 liters per minute. Resident #88 revealed she had been on oxygen use for some time and had the use of oxygen when she entered the facility. Resident #88 stated staff entered often to check her water level however it had been over a month since her nasal canula had been changed. Interview and observation on 07/25/24 at 11:13 AM, LVN H revealed him stating he did not see an order for Resident #88's oxygen use. LVN H stated, there should be an order for oxygen, and Resident #88 should not be given oxygen without one. LVN H stated nurses were responsible for ensuring resident orders reflect the care doctors have in place. LVN H stated not having an order for oxygen placed Resident #88 at risk of further respiratory concerns. Observation of Resident #88 in her bed with nasal canula in place, administering 3 liters per minute LVN H stated he did not see a date provided on the canula to indicate when it was provided to Resident #88. LVN H stated without the date, you would not be able to tell when it was last changed. LVN H stated not changing out the nasal canula would place Resident #88 at risk of bacteria, dust, and mold build up. LVN H stated both the nasal canula and the humidifier should be changed out and dated every Sunday night, by the nurse working the overnight shift. Interview on 07/25/24 at 5:47 PM, ADON C revealed she was notified about Resident #88 not having orders for oxygen by nursing staff. ADON C stated nursing staff were responsible for ensuring Resident #88 had an order for oxygen. ADON C stated she was responsible for review resident orders, ADON C stated she was not aware there were no current orders for Resident #88 and Resident #32. Interview on 07/25/24 at 6:20 PM, the Acting DON revealed residents who received oxygen should have oxygen orders. She stated they needed physician orders on anything that was given to a resident. She stated potential risk would not knowing when the tubing or water bottle needing to be changed. The Acting DON stated they was no negative affect on the resident concentrator not having water unless it was above 5 liters. She stated it was the responsibility of the charge nurse and ADONs or whoever applied the oxygen to ensure physician orders are obtained and tubing and concentrator water bottle are changed. Record review of the facility's policy titled Oxygen Safety dated 01/26/24, reflected the following: It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. The policy does not address the use of oxygen. 44937

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observations, interviews, and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for 4 (Resident #30, #75, #127 and #136) of 6 residents reviewed for dialysis. 1.The facility failed to maintain dialysis communication sheets for Residents #30, #75, #88, #127, and #136. This failure could place residents at risk of inadequate post dialysis care. Findings included: 1.Record review of Resident #30's undated Admission Record reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included kidney failure requiring dialysis, dementia, and diabetes. Record review of Resident #30's quarterly MDS, dated [DATE], reflected a BIMS score of 9, indicating she was mildly cognitively impaired. Her Special Treatments indicated she required dialysis. Record review of Resident #30's care plan, date 5/17/24, reflected she received hemodialysis every Monday, Wednesday, and Friday. Record review of Resident #30's dialysis binder for July 2024 reflected no communication sheets for July 3, 5, 8, 15, 17, 19, 22, and 24. Interview on 7/25/24 at 11:30 AM RN-D stated all dialysis communication sheets are turned in to Medical Records to be scanned into the resident's EHR. Interview on 7/25/24 at 11:40 AM the Director of Medical Records stated she did not scan the communication sheets into the EHR, they were to be left at the nurse's station in the dialysis binder. 2.Record review of Resident #75's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #75's admission MDS assessment, dated 07/12/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included unspecified atrial fibrillation, muscle wasting and atrophy, hypothyroidism, and end stage renal disease. The MDS further revealed Section O - Special Treatments, Procedures, and Programs indicated resident was receiving dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #75's care plan, revised on 05/16/24, reflected: Focus: [Resident #75] needs hemodialysis r/t chronic kidney disease. Goal: Will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Will have no s/sx of complications from dialysis through the review date. Interventions: Encourage resident to go for the scheduled dialysis appointments. Resident receives Dialysis provided by [Dialysis Center] Dialysis days are (MWF)at (2:30) Days may vary based on holidays and dialysis center schedule. Check and change dressing daily at access site. Document. Monitor VITAL SIGNS as indicated and as necessary. Notify MD of significant abnormalities. Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Record review of Resident #75's physician orders revealed no orders for dialysis, no orders to monitor port site or pre and post dialysis vitals. Record review of Resident #75's dialysis communication forms reflected only one communication form were able to be located dated 07/22/24. Post dialysis assessment and observation not completed. Observation and interview on 07/23/24 at 3:13 PM Resident #75 was sitting in his wheelchair. Resident #75 stated he was a dialysis patient and his char times were Mondays, Wednesdays, and Fridays. Resident #75 stated he was provided with a folder that he takes with him to dialysis and brings it back to the facility. Resident #75 denied any pain or discomfort to his port site. 3.Record review of Resident #88's face sheet, dated 07/25/2024, indicated Resident #88 was a [AGE] year-old female, admitted to the facility on [DATE]. Record review of admission MDS assessment, dated 06/29/2024, indicated Resident #88 had the ability to make herself understood and understood others. The assessment indicated Resident #88's BIMS score was 15, which indicated her cognition was intact. The assessment indicated Resident #88's diagnosis included had Chronic Kidney Disease, Stage 3, End Stage Renal Disease, and Dependence on Renal Dialysis. The MDS assessment further included Resident #88 was receiving dialysis. Record review of Resident #88's care plan, undated revealed resident had potential for fluid volume overload related to ESRD on hemodialysis, often refused dialysis requiring hospitalization due to renal complications/refusals. Goal: Resident #88 will remain free of signs and symptoms of fluid overload through review date as evidenced by decrease in or absence of edema, anxiety, agitation, restlessness, confusion, changes in mood or behavior, nausea/vomiting, dyspnea, congestion, orthopnea, easily fatigued, jugular vein distension. Interventions included Administer medications as ordered, monitor and document input and output, monitor/document/report any signs and symptoms of fluid overload, obtain and monitor lab/diagnostic work as ordered and report result to doctor, weights as ordered. Resident needs hemodialysis related to ESRD often refuses dialysis requiring hospitalization s due to renal complications/refusals. Goals: Resident #88 will have immediate intervention should any signs and symptoms of complications from dialysis occur. Resident #88 will have no signs and symptoms of complications from dialysis. Interventions included Check and change dressing daily at access site. Document. Encourage resident to go for the scheduled dialysis appointments. Fresenius Dialysis 200 [NAME] Blvd, (817-551-6623), Dialysis days: Tuesday-Thursday-Saturday, Chair Time: 11:30A, Days may vary based on holidays and dialysis center schedule. Monitor labs and report to doctor as needed. Monitor vital signs, notify doctor of significant abnormalities. Monitor/document signs of infection to access site: redness or swelling, warmth, drainage. Monitor/document/report signs of renal insufficiency. Monitor/document bleeding, hemorrhage, bacteremia septic shock, worsening peripheral edema. (continued on next page)

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	675622	A. Building B. Wing	07/25/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #88's physician orders revealed no orders for dialysis, no orders to monitor port site or pre and post dialysis vitals. Record review of Resident #88's dialysis communication forms reflected only one communication form were able to be located dated 07/22/24. Post dialysis assessment and observation not completed. Observation and interview on 07/23/24 at 12:13 PM Resident #88 was laying in bed. Resident #88 stated she attended dialysis and her char times were Mondays, Wednesdays, and Fridays. Resident #88 stated she was provided with a folder that she took with her to dialysis and brings it back to the facility. Resident #88 denied any pain or discomfort to her port site. Observation of the port cite was clean and clear of signs of infection. Resident #88 stated the facility monitored it when she returned from dialysis. 4. Record review of Resident #136's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #136's admission MDS assessment, dated 07/09/24, reflected a BIMS score of 06, which indicated severe cognitive impairment. Her diagnoses included chronic kidney disease, stage 3, dependence on renal dialysis. MDS further revealed Section O - Special Treatments, Procedures, and Programs indicated resident was receiving dialysis. Record review of Resident #136's care plan revised date 04/22/24 indicated dialysis was not cared plan. Record review of Resident #136's physician order dated 03/30/24 revealed Dialysis provided by [Dialysis Name] locate at [address] Dialysis days are Tuesday-Thursday-Saturday at 7:15 am Days may vary based on holidays and dialysis center schedule. Record review of Resident #136's physician order dated 03/30/24, revealed Permcath right chest: Monitor for signs and symptoms of infection or bleeding. Notify MD. every shift. Record review of Resident #136's dialysis communication forms reflected only communication form were able to be located dated 04/25/24, 05/07/24, 05/09/24, 06/27/24, 07/04/24, 07/06/24, 07/09/24, 07/11/24, and 07/13/24. Post dialysis assessment and observation not completed. Interview on 07/23/24 at 4:16 PM Resident #136 revealed she as doing well. Resident #136 stated she was a dialysis patient. Resident #136 stated she goes to dialysis Tuesdays, Thursdays, and Saturday. Resident #136 stated she could not recall if she was given any communication forms to take to dialysis. Resident #136 denied any discomfort or pain to her port site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/25/24 at 1:22 PM the ADON C revealed she was the ADON assigned to Resident #75, Resident #88 and Resident #136. She stated residents were dialysis patients. The ADON C stated when the residents go to dialysis, they provide the resident with a communication form to take to the dialysis. She stated nursing staff complete the pre and post dialysis communication forms. The ADON C reviewed Resident #75, Resident #88 and Resident #136 dialysis communication forms and stated they had several forms missing. She stated when a resident returns form dialysis the forms are placed in a bin and then the medical records upload them in the resident clinical chart. The ADON C stated she was unaware they needed to keep the forms in the resident chart and was not aware her nurses were not monitoring post dialysis vitals. She stated nurses were expected to check vitals, monitor, and document. She stated the risk of not monitoring or documenting would lead to infections and vital signs going up. Interview on 07/25/24 at 6:04 PM the Acting DON revealed her expectations were for the nurses to complete the dialysis communication forms pre and post dialysis vitals. Once the forms were completed the forms should be kept in the resident communication binder and to be upload into the resident's charts. She stated the potential risk would of not monitoring vitals could lead to fluctuation of vitals. 44140 44937

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 2 (Residents #35 and #246) of 6 residents reviewed for pharmaceutical services. 1.LVN F failed to follow physician orders for administering Exelon transdermal patch to Residents #35. 2.LVN K failed to follow the physician orders for administering medication to Resident # 246s, when he administered Nafcillin Sodium Injection Solution (Nafcillin Sodium) (antibiotic) 12g/1000mls intravenous to Resident #246. These failures could put residents at risk of not receiving their medications as ordered. Findings included: Review of Resident #35 's quarterly MDS assessment, dated 07/15/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included Parkinson's(is a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) and Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). The MDS assessment reflected the resident's BIMS was 2 indicating severely impaired cognition. Review of Resident #35's July 2024 Physician Orders reflected the following: Exelon Transdermal Patch 24 Hour 13.3MG/24HR(Rivastigmine). Apply 1 patch transdermal every 24 hours. Observation on 07/24/24 at 07:50 AM, revealed LVN F administering Exelon (Rivastigmine) Transdermal system patch 13.3/24 hrs (for the treatment of mild-to-moderate dementia associated with Parkinson's Disease), to Resident #35. She explained the procedure to Resident #35. She took the patch and put the date on it. She washed hands and put on gloves. She was observed removing the old patch dated 7/23/24 and another patch dated 7/19 was observed on the resident left upper back. LVN F removed both patches and she administered the one dated 7/24/24 on the right upper back. She removed the gloves and washed hands. Interview with LVN F on 07/24/24 at 08:15 AM, revealed she was the one that applied the patch dated 7/23/24 on Resident #35, she stated she did not see the patch dated 7/19/24. LVN F stated she was aware she was supposed to remove the old patch before administering the new one. She stated she had applied patch on 7/22/24 and 7/23/23 but she was not lifting the blouse she would put her arm inside the blouse remove the old and apply the new one but today she decided to lift the blouse up. She stated the risk of not removing the old patch was over medication and skin irritation. LVN F stated she had done in services on medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Review of Resident #246 's entry MDS assessment, dated 07/24/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection). Resident#246 MDS not completed she was newly admitted . Review of Resident #246's July 2024 Physician Orders reflected the following: Nafcillin Sodium Injection Solution Reconstituted 2 GM (Nafcillin Sodium) Use 12000 mg intravenously every 24 hours for Sepsis for 25 Days continuous IV infusion at 41c/hr. 12 mgs /1000mls. Observation on 07/24/24 at 09:45 AM, revealed LVN K administered Nafcillin sodium injection to Resident #246. He washed hands and put on the gown and mask. He took the bag of Nafcillin 12grams in 1000mls, tubing, alcohol swabs and intravenous flushes. He explained the procedure to Resident #246. He washed hands and put on gloves. He was observed removing a bag dated 7/23 at 09:30 and he placed in the trash can. The bag was observed to have 400mls of Nafcillin 400mls remaining. He hung another bag on the pole dated 7/24/24. He cleansed the picc line (peripherally inserted central catheter) with alcohol, flushed the picc line with 5mls of normal saline and connected the tubing administering at 41 mls every hour. He left resident comfortable removed the gloves cleared the table and washed hands. Interview with LVN K on 07/24/24 at 12:10 PM, revealed he was aware of the order to administer medication continuous for 24 hours for Resident #246, but he stated every morning when he changes the bag there is some residual left from 100mls. LVN K stated he understood every morning he had to hang a new bag regardless of whether the resident had gotten the whole amount or not .LVN K stated he was aware Resident #246 was supposed to get the whole dose of 12g of Nafcillin in 1000 mls in 24 hours, and he stated he had noticed the resident was not receiving the prescribed dose and he had not notified the doctor or the DON, but he did not have reason as to why he did not . He stated the risk of not administering the whole dose to Resident #246 was that the treatment was not effective, and it was slowing the healing. He stated he was aware the resident was missing some doses and that was leading to medication error. Interview with ADON B on 07/24/23 at 12:31 PM, revealed his expectation was for the nurses to administer the whole dose as per the doctor's orders and follow the facility policy. He stated he expected the nurses to monitor the flow and he stated he was not aware the resident was not getting the 1000mls. He stated the failure when the nurse threw the bag with medication Resident #246 was not receiving the correct dose and that would affect the effectiveness of the administered medication, slowing the healing. He stated he had trained the nurses on medication administration. Interview with the acting DON on 07/25/24 at 06:32 PM, revealed her expectation was for the nurses to monitor the flow and follow the doctor orders to administer a full dose. She stated she expected the bag to be empty by the time nurses were preparing to hang a new bag. She stated failure to administer the full dose could lead to Resident #246 not meeting the therapeutic level that is needed. She stated facility had trained the nurses on medications administration via intravenous. Interview with the acting DON on 07/25/24 at 06:47 PM, revealed her expectation was that nurses should remove the old patch before applying the new patch. She stated failure to remove the old patch would lead to overdose and skin irritation. She stated facility had done in-service on medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's current policy dated October 2019, Administering Medication Parenteral Administration policy and procedure, reflected the following: . 1. Read medication package literature, medication label, or other appropriate reference to determine the correct diluent and quantity of diluent to be used. . 9. Administer medication or add to intravenous (IV) solution as directed and complete. documentation. .11. Refer to facility approved IV Policy and Procedure Manual for further reference. 14. Administer medication as ordered in accordance with manufacturer specifications. Review of the facility's current policy dated October 2019, Administering Medication Transdermal (Patch) Application policy and procedure, reflected the following: 2. Identify the location on the body for patch placement. Always rotate application sites to prevent. irritation. C. Exelon patches should not be reapplied to the same site for more than 14 days. 3. Remove old patch from body. Fold in half with adhesive sides together. Discard according to facility policy 4. Cleanse area of old patch with a clean water wet gauze pad and pat dry with another gauze pad. 5. Cleanse area where new patch will be placed using clean water wet gauze pad and pat dry with another gauze pad. 6. Using gloves, remove new patch from package and envelope. Avoid touching the side of the patch that touches the resident's skin. 7. Label patch with date and nurse's initials. Do not write on patch after application to resident's skin. 8. Apply new patch firmly against skin.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater on 2 errors of 27 opportunities for errors leading to 7.41% medication error rates for two (LVN F and LVN K) of four staff observed for medication pass. 1. The facility failed to ensure LVN F administered medications as ordered to Resident #35 by administering Exelon patch (a treatment for Parkinson and dementia) without removing the old patch on 7/23/24. 2. The facility failed to ensure LVN K properly administered medications as ordered to Resident #246 when administering Nafcillin 12gm/1000mls every 24 hours, LVN K did not ensure the bag was completely empty (discarded 400mls) before administered a new bag. These failures resulted in a 7.41% medication error rate and could put residents at risk who received medications for not receiving the correct dose of medication and getting intended therapy. Findings include: 1.Review of Resident #35 's quarterly MDS assessment, dated 07/15/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included Parkinson's disease (is a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) and Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). The MDS assessment reflected the resident's BIMS score was 2 indicating severely impaired cognition. Review of Resident #35's July 2024 Physician Orders reflected the following: Exelon Transdermal Patch 24 Hour 13.3MG/24Hour (Rivastigmine). Apply 1 patch transdermal every 24 hours. Observation on 07/24/24 at 07:50 AM revealed LVN F administering Exelon (Rivastigmine) Transdermal system patch 13.3/24 hrs. (for the treatment of mild-to-moderate dementia associated with Parkinson's Disease), to Resident #35. She explained the procedure to Resident #35. She took the patch and put the date on it. She washed her hands and put on gloves. She was observed removing the old patch dated 7/23/24 and another patch dated 7/19/24 was observed on the resident's left upper back. LVN F removed both patches and she administered the one dated 7/24/24 on the right upper back. She removed the gloves and washed her hands. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN F on 07/24/24 at 08:15 AM revealed she was the one that had applied the patch dated 7/23/24 on Resident #35. She stated she did not see the patch dated 7/19/24. LVN F stated she was aware she was supposed to remove the old patch before administering the new one. She stated she had applied the patch on 7/22/24 and 7/23/24 but she was not lifting the blouse. LVN F said she would put her arm inside the blouse, remove the old patch, and apply the new one but today she decided to lift the blouse up. She stated the risk of not removing the old patch was over medication and skin irritation. LVN F stated she had done in services on medication administration. 2. Review of Resident #246 's entry MDS assessment, dated 07/24/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection). Resident #246's MDS was not completed as she was newly admitted . Review of Resident #246's July 2024 Physician Orders reflected the following: Nafcillin Sodium Injection Solution Reconstituted 2 GM (Nafcillin Sodium) Use 12000 mg intravenously every 24 hours for Sepsis for 25 Days continuous IV infusion at 41c/hr . 12 mgs /1000mls. Observation on 07/24/24 at 09:45 AM revealed LVN K administered Nafcillin sodium injection to Resident #246. He washed his hands and put on the gown and mask. He took the bag of Nafcillin 12grams in 1000mls, tubing, alcohol swabs and intravenous flushes. He explained the procedure to Resident #246. He washed his hands and put on gloves. He was observed removing a bag dated 7/23/24 at 09:30 AM and he placed in trash can. The bag was observed to have 400mls of Nafcillin remaining. He hanged another bag on the pole dated 7/24/24. He cleansed the PICC line with alcohol, flushed the PICC line with 5mls and connected the tubing administering at 41 mls every hour. He left Resident #246 comfortable, removed the gloves, cleared the table, and washed his hands. Interview with LVN K on 07/24/24 at 12:10 PM revealed he was aware of the order to administer medication continuous for 24 hours for Resident #246, but he stated every morning when he changes the bag there is some residual left from 400mls . LVN K stated he understood every morning he had to hang a new bag regardless of whether the resident had gotten the whole amount or not. LVN K stated he was aware Resident #246 was supposed to get the whole dose of 12g of Nafcillin in 1000 mls in 24 hours, and he stated he had noticed the resident was not receiving the prescribed dose and he had not notified the doctor or the DON, but he did not have reason as to why he did not . He stated the risk of not administering the whole dose to Resident #246 was that the treatment was not effective, and it was slowing the healing. He stated he was aware the resident was missing some doses and that was leading to medication error. Interview with ADON B on 07/24/24 at 12:31 PM revealed his expectation was for the nurses to administer the whole dose as per the doctor's orders and follow the facility policy. He stated he expected the nurses to monitor the flow and he stated he was not aware the resident was not getting the 1000mls. He stated the failure when the nurse threw away the bag with medication remaining, ADON B stated LVN K should have contacted the doctor if Resident #246 was not receiving the full dose. ADON B stated when residents were not getting their full dose of medications it would affect the effectiveness of the administered medication, slowing the healing. He stated he had trained the nurses on medications administration. There was residual because LVN K replaced the bag prior to its completion. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the acting DON on 07/25/24 at 06:32 PM revealed her expectation was for LVN K and all Resident #246's nurses to monitor the flow and follow the doctor orders to administer a full dose. She stated she expected the bag to be empty by the time nurses were preparing to hang a new bag. DON stated she was not aware Resident #246 was not getting his full dose. She stated failure to administer the full dose could lead to Resident #246 not meeting the therapeutic level that is needed. She stated facility had trained the nurses on medications administration via intravenous route. Interview with the acting DON on 07/25/24 at 06:47 PM revealed her expectation was that nurses should remove the old patch before applying the new patch. She stated failure to remove the old patch would lead to overdose and skin irritation. She stated facility had done in-service on medication administration. Review of the facility's current policy dated October 2019, Administering Medication Parenteral Administration policy and procedure, reflected the following: . 1. Read medication package literature, medication label, or other appropriate reference to determine the correct diluent and quantity of diluent to be used. . 9. Administer medication or add to intravenous (IV) solution as directed and complete. documentation. .11. Refer to facility approved IV Policy and Procedure Manual for further reference . 14. Administer medication as ordered in accordance with manufacturer specifications. Review of the facility's current policy dated October 2019, Administering Medication Transdermal (Patch) Application policy and procedure, reflected the following: 2. Identify the location on the body for patch placement. Always rotate application sites to prevent. irritation. C. Exelon patches should not be reapplied to the same site for more than 14 days. 3. Remove old patch from body. Fold in half with adhesive sides together. Discard according to facility policy 4. Cleanse area of old patch with a clean water wet gauze pad and pat dry with another gauze pad. 5. Cleanse area where new patch will be placed using clean water wet gauze pad and pat dry with another gauze pad. 6. Using gloves, remove new patch from package and envelope. Avoid touching the side of the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patch that touches the resident's skin. 7. Label patch with date and nurse's initials. Do not write on patch after application to resident's skin. 8. Apply new patch firmly against skin.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44140 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food items were kept away from potential airborne contaminants (dust and fuzz) on the ceiling vents. This failure could place residents at risk for food contamination and food-borne illness. Findings included: Observation on 07/23/24 at 8:55 AM revealed a total of ten air conditioning vents in the kitchen area were observed to have built-up fuzz and dust stuck to them. Interview on 07/24/24 at 11:55 AM with Dietary Aide revealed all kitchen staff were responsible for cleaning kitchen equipment. She stated all kitchen staff had daily assignments. Dietary Aide stated maintenance staff were responsible for cleaning the air vents. She stated she could not recall when was the last time air vents were cleaned. She stated the air vents needed to be clean because of all the build-up. She stated kitchen staff would report to the Food Service Supervisor and the Food Service Supervisor would notify the maintenance staff. Dietary Aide stated the risk of air vents not being cleaned could lead to build-up falling in the food. Interview on 07/24/24 at 11:59 AM with [NAME] revealed kitchen staff had daily scheduled assignments to clean the kitchen. He stated he could not recall if the air vents were cleaned by an outside vendor or by maintenance staff. He stated he could not recall when was the last time air vents were cleaned. [NAME] stated the risk of air vents not being cleaned could lead into dust falling in the food. Interview on 07/24/24 at 12:02 PM with Food Service Supervisor revealed the kitchen staff had a daily, weekly, and monthly cleaning schedule to clean the kitchen. She stated the maintenance staff were responsible for cleaning the air vents. She stated the last time the air vents were last cleaned was about 6 months ago. The Food Service Supervisor stated last month in June 2024 they had a Quality Assurance Monitor (QA) audit and the ceiling vents was one of the requirements that were not met. She stated she had reported to maintenance staff the air vents needed to be cleaned. She stated the risk of air vents not being cleaned could lead to build-up falling in the food. Interview on 07/25/24 at 4:20 PM with Maintenance Director revealed the kitchen air vents were cleaned by kitchen staff and maintenance staff. He stated a couple of weeks ago it was reported to him that the kitchen air vents needed to be cleaned. He stated he could not recall the exact date; however, they had a system where requests are put in and the maintenance staff had 30 days to complete the request. He stated it was his responsibility to ensure task were completed. Maintenance Supervisor stated he had not had the opportunity to get it done. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of facility Quality Assurance Monitor I Kitchen/Food Service Observation dated 06/04/24 reflected Section 2: General Sanitation and Cleanliness - General appearance of kitchen clean: floors, walls, ceilings, vents ., was marked No. Record review of the facility's policy titled Sanitization dated January 2013, reflected the following: The food service area shall be maintained in a clean and sanitary manner. All kitchen, kitchen areas and dining areas shall be kept clean . Record review of the Federal Food Code 2022 reflected the following: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on record review and interview, the facility failed to conduct and document a facility wide assessment that addressed the care required by the resident population and the facility's resources for 1 of 1 facility assessment, in that: -The facility assessment inaccurately reflected that there were no dialysis patients in the facility. -The facility assessment did not include contracts, memorandums of understanding, or other agreements with third parties to provide services for dialysis. This deficient practice could place residents at-risk for inadequate care or treatments due to an inaccurate assessment. The findings included: Record Review of Resident #18's face sheet, dated 08/01/24, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE]. His diagnoses included end stage renal disease, dependance on renal dialysis, and unspecified dementia (memory loss). Record Review of Resident #18's annual MDS Assessment, dated 05/16/24, reflected that the resident had a BIMS score of 9 suggesting the resident was moderately impaired. Record Review of Resident #18's care plan, dated 07/25/24, revealed he was initially evaluated and began dialysis on 06/05/23. Record Review of Resident #18's orders reflected the resident's dialysis order was dated 8/17/23. Record review of dialysis contract revealed that the facility did not have a contract with the dialysis provider on 7/25/24 at 6:27 PM. Record review of the Facility Assessment Tool dated 5/10/24 (date of assessments or update) read in part: . Pg. 3 . Special Care Needs . dialysis. Present in Facility . y/n . n. . Pg. 8 . Healthcare Related Contracts . Dialysis . no contract . Record review of email from the DON on 7/23/24 at 6:46 PM revealed that the facility had seven dialysis patients in the facility at the time of the survey. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/25/24 at 7:10 PM with DON revealed that she was unaware that the facility assessment was inaccurately completed. She stated that the facility assessment is not a nursing task, and that the facility assessment is an administrator responsibility. DON also stated that if the facility assessment reflects that there are no dialysis patients in the facility, then the facility assessment is incorrect. DON also stated that there should be dialysis contracts and was not aware that the facility did not have contracts with the residents' dialysis centers and that the administrators are responsible for contracts with outside resources. DON continued by revealing if there is no contract with a dialysis facility, there is a potential risk in break of treatment which could cause harm to the resident. Interview on 07/25/24 at 7:16 PM with Administrator revealed that he did not complete the facility assessment. The Administrator stated that he assigned the facility assessment to the maintenance director because his role as the administrator is to delegate his responsibilities to staff. The Administrator also said his maintenance director did not know the residents' medical conditions. Administrator revealed that he knew that there were residents in the facility that required dialysis. The administrator also stated that the facility did not have dialysis contracts and did not need dialysis contracts. Administrator stated that the residents' doctors choose the dialysis centers, so the nursing home facility does not need to get a contract with the dialysis center since it is an arrangement that doctors order. A record review of the facility's policy dated 10/24/22 reflected and titled Facility Assessment, Policy Statement: This facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operation and emergencies. 1. a. ii. The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population. b. v. Contracts, memorandum of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. .

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to ensure agreements pertaining to services furnished by outside resources specified in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility for 1 of 1 dialysis facilities reviewed for dialysis services. -The facility did not have a written agreement with the dialysis center for Resident #18. This failure could place residents requiring dialysis at risk for failure to receive dialysis services due to lack of coordination of care with a dialysis center and therefore potential physical harm and psychosocial harm. Findings include: Record Review of Resident #18's face sheet, dated 08/01/24, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE]. His diagnoses included end stage renal disease, dependance on renal dialysis, and unspecified dementia (memory loss). Record Review of Resident #18's annual MDS Assessment, dated 05/16/24, reflected that the resident had a BIMS score of 9 suggesting the resident was moderately cognitively impaired. Record Review of Resident #18's care plan, dated 07/25/24, revealed he was initially evaluated and began dialysis on 06/05/23. Record Review of Resident #18's orders reflected the resident's dialysis order was dated 8/17/23. Record review of dialysis contract revealed that the facility did not have a contract with the dialysis provider on 7/25/24 at 6:27 PM. Interview with DON on 07/25/24 at 7:10 PM revealed that the DON was not aware that the facility did not have contracts with dialysis facilities and was aware that the facility currently had dialysis patients. DON stated that the administrator is responsible for obtaining facility contracts with outside resources. DON also stated that if there is no contract with a dialysis facility, there is a potential risk of break in treatment which could cause harm to the resident. Interview with the Administrator on 07/25/24 at 7:16 PM revealed the facility did not have dialysis contracts. Interview also revealed the administrator was aware the facility had residents currently on dialysis. The administrator stated that the facility did not have dialysis contracts and did not need dialysis contracts. Administrator also said that the residents' doctors choose the dialysis centers, so the nursing home facility does not need to get a contract with dialysis centers since it is an arrangement that doctors order. Record review of outside policies on 07/25/24 at 7:20 PM revealed the facility did not have a dialysis policy and no facility policy for working with outside resources.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review, the facility failed to maintain clinical records that were complete and accurate for five (Resident #30, #18, #88, #75, and #127) of six residents reviewed for clinical records. 1. The facility failed to obtain a physician order for Dialysis for Resident #30. 2. The facility failed to obtain a physician order for Dialysis for Resident #18. 3. The facility failed to obtain a complete physician order for Dialysis for Resident #127. 4. The facility failed to obtain a physician order for Dialysis for Resident #88. 5. The facility failed to obtain a physician order for Dialysis for Resident #75. This failure could place residents at risk for incomplete and inaccurately documented medical record that included their progress treatment, services, and interventions. Findings include: 1. Record review of Resident #30's undated Admission Record reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included kidney failure requiring dialysis, dementia, and diabetes. Record review of Resident #30's quarterly MDS assessment, dated 5/13/24, reflected a BIMS score of 9, indicating she was moderately cognitively impaired. Her Special Treatments indicated she required dialysis. Record review of Resident #30's care plan, date 5/17/24, reflected she received hemodialysis every Monday, Wednesday, and Friday. Record review of Resident #30's physician orders reflected no physician order for the resident to receive dialysis. Interview on 7/23/24 at 9:42 AM Resident #30 stated she had been leaving the facility three times a week for her dialysis, every Monday, Wednesday, and Friday. She stated the facility always got her to her appointment on time, 2. Record review of Resident #18's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included kidney failure requiring dialysis, dementia, diabetes, and traumatic brain injury. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's quarterly MDS assessment, dated 5/16/24, reflected a BIMS score of 9 indicating he had moderate cognitive impairment. His Special Treatments assessment reflected he required hemodialysis. Record review of Resident #18's care plan, dated 5/20/24, indicated he received dialysis every Tuesday, Thursday, and Saturday. Record review of Resident #18's physician orders reflected he had no order for dialysis. 3. Record review of Resident #127's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included kidney failure requiring dialysis, dementia, and high blood pressure. Record review of Resident #127's quarterly MDS, dated [DATE], reflected a BIMS score of 14, indicating he was cognitively intact. His Special Treatments assessment reflected he required hemodialysis. Record review of Resident #127's care plan, dated 7/17/24, reflected he received dialysis every Monday, Wednesday, and Friday. Record review of Resident #127's physician orders reflected an incomplete order for dialysis written on 1/10/24: Dialysis provided by (name of dialysis center) located at (dialysis center address) (phone number). Dialysis days are (specify days) at (specify chair time) Days may vary based on holidays and dialysis center schedule. 4. Record review of Resident #88's face sheet, dated 07/25/2024, indicated Resident #88 was a [AGE] year-old female, admitted to the facility on [DATE]. Record review of admission MDS assessment, dated 06/29/2024, indicated Resident #88 had the ability to make herself understood and understood others. The assessment indicated Resident #88's BIMS score was 15, which indicated her cognition was intact. The assessment indicated Resident #88's diagnosis included had Chronic Kidney Disease, Stage 3, End Stage Renal Disease, and Dependence on Renal Dialysis. The MDS assessment further included Resident #88 was receiving dialysis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #88's care plan, undated revealed Resident had potential for fluid volume overload related to End Stage Renal Disease on hemodialysis, often refused dialysis requiring hospitalization due to renal complications/refusals. Goal: Resident #88 will remain free of signs and symptoms of fluid overload through review date as evidenced by decrease in or absence of edema (fluid retention/swelling), anxiety, agitation, restlessness, confusion, changes in mood or behavior, nausea/vomiting, dyspnea (feeling of having shortness of breath), congestion, orthopnea (shortness of breath while laying flat), easily fatigued, jugular vein distension (veins that take blood from the head back to the heart). Interventions included Administer medications as ordered, monitor and document input and output, monitor/document/report any signs and symptoms of fluid overload, obtain and monitor lab/diagnostic work as ordered and report result to doctor, weights as ordered. Resident needs hemodialysis related to ESRD often refuses dialysis requiring hospitalization s due to renal complications/refusals. Goals: Resident #88 will have immediate intervention should any signs and symptoms of complications from dialysis occur. Resident #88 will have no signs and symptoms of complications from dialysis. Interventions included Check and change dressing daily at access site. Document. Encourage resident to go for the scheduled dialysis appointments. [Dialysis Center name and address] Dialysis days: Tuesday-Thursday-Saturday, Chair Time: 11:30A, Days may vary based on holidays and dialysis center schedule. Monitor labs and report to doctor as needed. Monitor vital signs, notify doctor of significant abnormalities. Monitor/document signs of infection to access site: redness or swelling, warmth, drainage. Monitor/document/report signs of renal insufficiency. Monitor/document bleeding, hemorrhage, bacteremia septic shock, worsening peripheral edema. Record review of Resident #88's physician orders revealed no orders for dialysis, no orders to monitor port site or pre and post dialysis vitals. Record review of Resident #88's dialysis communication forms reflected only one communication form were able to be located dated 07/22/24. Post dialysis assessment and observation not completed. Observation and interview on 07/23/24 at 12:13 PM of Resident #88 revealed resident was laying in bed. Resident #88 stated she attended dialysis and her chair times were Mondays, Wednesdays, and Fridays. Resident #88 stated she was provided with a folder that she took with her to dialysis and brings it back to the facility. Resident #88 denied any pain or discomfort to her port site. Observation of the port site revealed it was clean and clear of signs of infection. Resident #88 stated the facility monitored it when she returned from dialysis. 5. Record review of Resident #75's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #75's admission MDS assessment, dated 07/12/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included unspecified atrial fibrillation (an abnormal heart rhythm), muscle wasting and atrophy, hypothyroidism, and end stage of renal disease. MDS further revealed Section O - Special Treatments, Procedures, and Programs indicated resident was receiving dialysis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #75's care plan, revised on 05/16/24, reflected: Focus: [Resident #75] needs hemodialysis r/t chronic kidney disease. Goal: Will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Will have no s/sx of complications from dialysis through the review date. Interventions: Encourage resident to go for the scheduled dialysis appointments. Resident receives Dialysis provided by [Dialysis Center] Dialysis days are (MWF)at (2:30) Days may vary based on holidays and dialysis center schedule. Check and change dressing daily at access site. Document. Monitor VITAL SIGNS as indicated and as necessary. Notify MD of significant abnormalities. Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Record review of Resident #75's physician orders revealed no orders for dialysis, no orders to monitor port site or pre and post dialysis vitals. Observation and interview on 07/23/24 at 3:13 PM of Resident #75 revealed resident was sitting in his wheelchair. Resident #75 stated he was a dialysis patient and his char times were Mondays, Wednesdays, and Fridays. Resident #75 stated he was provided with a folder that he takes with him to dialysis and brings it back to the facility. Resident #75 denied any pain or discomfort to his port site. Interview on 07/25/24 at 1:22 PM with ADON C revealed she was the nurse assigned to Resident #75. She stated Resident #75 was a dialysis patient. She stated Resident #75 should have a physician order for dialysis. The ADON C reviewed Resident #75 physician order and stated that resident did not have an order for dialysis. She stated Resident #88 should have physician orders for dialysis. She stated she does not know how that was missed. She stated it was her responsibility to review orders when a resident was admitted . She stated the physician order was missed. The ADON C stated the risk of not having physician orders could lead to new staff or PRN staff not knowing resident was a dialysis patient. Interview on 07/25/24 at 6:07 PM with the Acting DON revealed she was not aware these residents did not have orders for dialysis, however, her expectations are for residents to have physician orders for dialysis. She stated it was the responsibility of the nurse admitting the resident to put in the orders and the responsibility of the ADON and DON to review them. She stated there should be an order for port monitor and pre and post vital check. She stated the potential risk of not having physician order could lead to resident missing dialysis and risk of infection if dialysis port were not being monitor. Record review of the facility's policy titled Documentation in Medical Record dated 10/24/22, reflected the following: 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. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. (continued on next page)

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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. iii. Subjective information shall be recorded only as relevant, such as the resident's verbalizations, in quotation marks. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 44140

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to designate a member of the facility's interdisciplinary team to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 2 residents (Residents #109 and #119) reviewed for hospice services. The facility failed: 1. To obtain Resident #119's physician's order for hospice services. 2. To obtain Resident #109's physician's order to discharge from hospice services. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record Review of Resident #119's face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included acute myeloblastic leukemia, not have achieved remission (a type of cancer), dementia (memory loss), a fractured clavicle (collarbone) , and anxiety. Record Review of Resident #119's annual MDS Assessment, dated 07/08/24, reflected that the resident did not have a BIMS score because the resident is rarely/never understood. Record Review of Resident #119's care plan, dated 05/02/24, revealed she was initially evaluated and admitted to Hospice Service Company on 11/03/21. Record Review of Resident #119's orders reflected the resident did not have a physician's order for hospice services. Interview on 07/25/24 at 12:31 PM with CNA E revealed Hospice Service Company sends their CNAs to give Resident#119 her shower. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/25/24 at 12:46 PM with LVN F revealed that there should be an order to admit to hospice in place. LVN F stated after looking through Resident #119's EHR that there was not an order to admit to hospice services. LVN F stated that it is important to have an order in place so that everyone involved in the resident's care knows that the resident is on hospice. LVN F also said that Resident #119 transferred from another wing in the facility. And LVN F verified an order for hospice care should have been in Resident #119's EHR before being assigned to her wing. LVN F stated that there is a risk to the resident if there is no order to admit to hospice because the resident can have a change in condition and a nurse would not know to contact hospice. For example, if the resident needed medication, hospice would need to be informed for both financial and health reasons so that hospice could order the medication. Interview on 07/25/24 at 12:51 PM with ADON A revealed that Resident #119 is supposed to have an order to admit to hospice. ADON A stated that it is important to have an order because the payor source is hospice for some medications, and a medication may be denied for payment sources. ADON A also stated that there is a communication that should occur between hospice nurses and the facility nurses. If this does not occur, the risk to the resident is that the patient can continue to decline, and the effectiveness of the patient's care is at risk. ADON A also stated that the care plan is an example where if communication does not occur, a correct care plan is not put into place and effective care cannot occur. Interview on 07/25/24 at 7:05 PM with DON revealed that there should be an order to admit to hospice as well as a care plan. DON stated that this is important for continuity of care and assists in providing care to the resident. DON also revealed that there would be a risk to the resident if there is no order to admit to hospice because if a change in condition occurs, the resident's rights could possibly be violated if the resident is sent out to an emergency room . Record Review of Resident #109's face sheet dated 07/25/24 reflected an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #109 had diagnoses which included senile degeneration of the brain, unspecified dementia, need for assistance for with personal care, and adjustment disorder with depressed mood. Record review of Resident #109's Comprehensive MDS assessment, dated 06/19/24 reflected Resident #109 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment reflected she was not receiving hospice services. Record Review of Resident #109's orders dated 12/22/22 reflected hospice to evaluate and admit to services. Record Review of Resident #109's care plan dated 07/02/24 reflected no hospice care plan or hospice services. Interview on 07/25/24 at 2:50 PM with LVN F revealed that Resident #109 was on hospice services but is no longer on hospice services. LVN F stated that if someone comes off hospice, an order to discharge off hospice services is supposed to be written by a physician. LVN F said that she remembers the hospice nurse telling her that she mailed the family member a letter that they were stopping hospice services. LVN F stated that hospice stopped providing services. LVN F also said that there is possible risk to the resident if a resident stops receiving hospice services and staff are not aware like facility aides not providing showers. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/25/24 at 3:10 PM with ADON A revealed that Resident #109 is not on hospice. ADON A stated the hospice company was not able to re-certify her for services. She also stated that there should be a discharge order to stop hospice. ADON A said that there would be a communication barrier with no stop order and services would be interrupted for a small amount of time. ADON-A stated that she would write the order to discharge the resident off hospice. Interview on 07/25/24 at 7:05 PM with DON revealed that there should be an order to admit to hospice as well as a discharge to hospice if per physician's orders and care plans should reflect the orders. DON stated that this is important for continuity of care and assists in providing care to the resident. DON also revealed that there would be a risk to the resident if there is no order to admit or discharge to hospice and if a change in condition occurs, the resident's rights could possibly be violated if the resident is sent out to an emergency room . Record review on 07/25/24 at 7:20 PM revealed the facility did not have a hospice policy. The DON stated she would be conducting hospice education.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observations, record reviews, and interviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 (Residents #25, #71, #103 and #244) of 10 residents reviewed for infection control. 1. The facility failed to provide signage and PPE for Resident #71, who was on Enhanced Barrier Precautions (EBP). 2. LVN L failed to don appropriate PPE (gowns) before providing bolus feeding to Resident #103, who was on Enhanced Barrier Precautions. 3. LVN K failed to perform hand hygiene, disinfect the blood pressure cuff between residents while monitoring blood pressure to Resident #25,and #244 and while administering medication to Residnet#25. This failure could place residents at risk of contracting an infection from residents on Enhanced Barrier Precautions. and cross contamination, which could result in infections or illness. Findings included: 1.Record review of Resident #71's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included heart attack, urinary tract infection, heart failure, and high blood pressure. Record review of Resident #71's quarterly MDS assessment, dated 6/28/24, reflected a BIMS score of 8, indicating moderate cognitive impairment. His Functional Status assessment indicated he required partial assistance with all of his ADLs. His Bladder and Bowel Assessment indicated he required the use of an indwelling catheter. Record review of Resident #71's care plan, dated 7/03/24, reflected he had an indwelling catheter that was initiated on 4/24/24. The care plan does not indicate he required EBP. Observation on 7/25/24 at 9:22 AM reflected Resident #71 had a urinary catheter in place. There was no signage outside the resident's room to indicate the resident was on EBP. There was no PPE available outside Resident #71's room, as there was for other residents on EBP. CNA-A entered the resident's room to empty the resident's catheter collection bag, wearing only gloves. Interview on 7/25/24 at 10:00 AM CNA-G stated she was unaware Resident #71 was on EBP or that she was required to wear a gown and gloves when performing all cares. Interview on 7/25/24 at 2:20 PM LVN-H stated he was not aware Resident #71 required EBP. LVN-B was unable to verbalize which type of residents required EBP, he had to consult with another nurse. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/25/24 at 2:35 PM LVN-I stated any resident with a urinary catheter or infections required EBP when providing care. Interview on 7/25/24 at 3:00 PM RN-J identified residents with IV access and urinary catheters required EBP. Interview on 7/25/24 at 3:10 PM the Acting DON stated all residents with any invasive devise were required to be placed on EBP. She stated it included urinary catheters, feeding tubes, IV access, and open wounds among other things. She stated the purpose of EBP was to prevent staff from infecting the resident. 2. Record review of Resident #103's Face sheet, dated 07/25/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #103's quarterly MDS assessment, dated 07/15/24, reflected his diagnoses included unspecified sequelae of cerebral infarction (stroke), hypertension and dysphagia (difficulty swallowing). Resident #103's BIMS score was not completed due to resident being rarely/never understood. MDS further revealed Section K - Nutritional Approaches were feeding tube. Record review of Resident #103's care plan, revised on 04/12/24, reflected: Focus: [Resident #103] requires tube feeding r/t dysphagia. Goal: [Resident #103] will remain free of side effects or complications related to tube feeding through review date. [Resident #103] will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions: [Resident #103] is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Care plan did not indicate he required EBP. Record review of Resident #103's physician order, dated 07/15/24, reflected Enteral Feed Order every shift Flush feeding tube with (30ml) of water before and after medication administration. Record review of Resident #103's physician order, dated 07/24/24, reflected Enteral Feed order six times a day free water 100 ml before and after each bolus. Observation on 07/25/24 at 8:24 AM revealed LVN L preparing to provide Resident #103 medications and bolus feeding. Observed Resident #103 to have a sign on the door stating Stop, Full PPE Required - Gown and Gloves. Do not enter without them!!. There was no observation of PPE outside the room. Observed LVN L conduct appropriate hand hygiene and then proceed to don gloves. LVN L failed to don gown. LVN L then was observed to provide Resident #103 medications and bolus feeding. Interview on 07/25/24 at 9:53 AM with LVN L stated she was the nurse assigned to Resident #103. LVN L stated any resident who had a catheter, g-tube, or wound was on Enhanced barrier precautions. She stated Resident #103 was on Enhanced barrier precautions due to the g-tube. She stated she should have donned a gown but forgot to do it. She stated the risk would be spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/25/24 at 5:02 PM with the ADON C revealed her expectations are for staff to don PPE when providing care to a resident who had a wound, catheter, or a g-tube. She stated residents who were on Enhanced Barrier Precautions had signs on doors to indicate the resident was on Enhanced Barrier Precautions. The ADON C stated Resident #103 was on Enhanced Barrier Precautions due to the g-tube and staff should don PPE (gown, gloves and mask) before providing any type of care. She stated the potential risk of not donning PPE would be spread of infection. Interview on 07/25/24 at 6:13 PM with Acting DON revealed her expectations are for nursing staff to observe the signs on the doors which indicated if the resident was on isolation or EBP. She stated when providing care to any resident who had a PICC-line, foley catheter, g-tube, infection, or any chronic wound longer than 30 days, nursing staff should don PPE. The potential risk would be spread of infection. 3. Review of Resident #25's entry MDS assessment, dated 07/04/24, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included elevated blood pressure, and fracture of shaft right ulna. Resident#25 had intact cognition with a BIMS score of 14. Review of Resident #244's entry MDS assessment, dated 07/09/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses including elevated blood pressure. Resident#244 had intact cognition with a BIMS score of 15. Observation on 07/24/24 at 06:59 AM revealed LVN K, performing morning medication pass. LVN K failed to perform hand hygiene while he checked Resident #244's blood pressure. LVN K did not disinfect the blood pressure cuff after using it on Resident #244. LVN K put the blood pressure cuff on top of the medication cart after use. He failed to perform hand hygiene before he prepared the medications for Resident#244. Observation on 07/24/24 at 07:01 AM revealed LVN K performing morning medication pass. LVN K failed to perform hand hygiene disinfect the blood pressure cuff before he checked Resident #25's blood pressure with the cuff that he had used on Resident#244. LVN K did not disinfect the blood pressure cuff after using it on Resident #244. He was also observed preparing medications for Residnet#25 without performing hand hygiene. He went to the room and Resident #25 requested her pills to be separated. LVN K was observed using his bare hands to touch the pills as he put them in a different cup. Interview on 07/24/24 at 07:07 AM, LVN K revealed he was supposed to disinfect the blood pressure cuff between the resident and perform hand hygiene before and after contact, but it skipped his mind. He stated he got nervous. LVN K stated he was aware he was supposed to either perform hand hygiene between residents and use a spoon or put on gloves to separate Resident #25's pills, but he forgot as he was focused on passing the medication to all residents. LVN K stated he was aware he was supposed to disinfect the blood pressure cuff, perform hand hygiene to prevent contamination and spread of infection. LVN K stated he had done training on infection control. Interview on 07/24/24 at 12:31 PM, ADON B revealed his expectation was that staff should disinfect items shared by residents between each resident to prevent contamination and spread of infection. He stated he also expected staffs to perform hand hygiene before and after contact with residents and use spoons in case they need to separate residents' medication. ADON B stated they should not use bare hands. He was responsible of monitoring the staff. The ADON B stated staff had done training on infection control, hand washing and disinfection of reusable items. (continued on next page)

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	675622	A. Building B. Wing	07/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/25/24 at 06:40 PM, the Acting DON revealed her expectation was that staff should disinfect items shared by residents between each resident to prevent contamination and spread of infection. The DON also stated her expectation was LVN K should have used a spoon or washed his hands and put on gloves to separate the medications .She stated the DON was responsible of monitoring the staff. The acting DON stated the facility had done training with staff on infection control. Record review of facility trainings revealed training on hand washing and blood pressure cuff disinfection dated 07/14/24 and 7/25/24 dated 4/12/24, LVN K was in attendance. Record review of the facility's policy Enhanced Barrier Precautions, dated 4/5/24, reflected: Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 1. Prompt recognition of need: a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. Record review of facility's infection prevention and control program policy, dated May 13th, 2023, reflected: 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. 10. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Record review of facility's Medication Administration policy, dated October 24 th 2022 reflected. 13. Remove medication from source, taking care not to touch medication with bare hand. 43791 44140

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observations, record reviews, and interviews the facility failed to ensure resident rooms were equipped to assure full visual privacy for each resident for 6 (Rooms 321. 322, 323, 324, 325, 327) of 6 rooms reviewed for full visual privacy. The facility failed to ensure privacy curtains in rooms Rooms 321. 322, 323, 324, 325, 327 could provide full visual privacy for both residents. This failure could cause a decrease in feelings of self-worth by being exposed during cares. Findings included: Record review of Resident #71's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included heart attack, urinary tract infection, heart failure, and high blood pressure. Record review of Resident #71's quarterly MDS assessment, dated 6/28/24, reflected a BIMS score of 8, indicating moderate cognitive impairment. His Functional Status assessment indicated he required partial assistance with all of his ADLs. His Bladder and Bowel Assessment indicated he required the use of an indwelling catheter. Record review of Resident #71's care plan, dated 7/03/24, reflected he had an indwelling catheter that was initiated on 4/24/24. The resident also had trauma to his penile shaft from the catheter requiring dressing changes daily. Observation on 7/25/24 at 10:00 AM revealed Resident #71's privacy curtain at the foot of his bed did not provide full visual privacy. Prior to wound care, Resident #71 asked to have the curtain pulled so that he was not visible from the doorway. Observation revealed the curtain, when pulled fully, left a gap at one end or the other of about 18-24 inches. Interview on 7/25/24 at 10:15 AM Resident #71 stated he did not like his curtain not covering the full length of his bed, but he always told staff to make sure the curtain was pulled to the door side at least. Resident #71 stated it had been that way since he moved in. Observations on 7/25/24 from 10:15 AM to 10:25 AM revealed the privacy curtains for five other rooms (rooms 322, 323, 324, 325, 327) on 300 Hall also failed to provide full visual privacy for both residents. The privacy curtain at the foot of the beds would only cover one resident. Interview on 7/25/24 at 3:10 PM The Administrator stated the facility had no policy to cover privacy curtains.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 43791 Based on observations, record reviews, and interviews the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents for 4 (Residents # 93, #236, #243, and #435) of 8 residents reviewed for pest control. The facility failed to ensure Residents # 93, #236, #243, and #435 were free from risk of mosquito bites. This failure could place residents at risk of exposure to viruses spread by mosquitos. Findings included: Phone interview/ Observation on 7/22/24 at 12:10 PM Resident #435 stated on 7/7/24 she suffered multiple mosquito bites to her hands, arms, neck and face during the night while sleeping. She notified the staff on the morning of 7/8/24 and they applied ointment to her bites. Observation of photos submitted by Resident #435 to the surveyor which appeared to show 11 bites to her right hand, and two blisters; 8 bites to her right forearm; 15 bites to her left forearm; 2 bites to her right neck; and 6 bites to her right face. Interview and observation on 7/23/24 at 3:00 PM Resident # 236 stated he was bitten several times by mosquitos about two weeks prior. Resident revealed 2 bites to his right elbow, 1 bite to the thumb web of his left hand, and one bite to the back of his left upper arm. Resident #236 stated staff sprayed him with something and he did not have any problems after that. No insects were observed in his room. Interview on 7/23/24 at 3:05 PM Resident # 243 stated he had several bites to the top of his bald head two weeks ago but they had resolved now. The resident stated he had observed mosquitos in his room. Resident stated he had been sprayed with something and there had been no problems since then. Interview on 7/23/24 at 3:10 PM Resident #93 stated he had been bitten by mosquitos several times on his arms about two weeks prior, but they had resolved now. He had observed mosquitos in his room earlier. Record review of nursing notes for Resident #435 revealed LVN-K documented on 7/9/24 Resident reported on Sunday to have irritation to the mosquito bites that have resulted in some blisters to her right wrist. Wound care aware. Wound care MD notified via wound care. Record review of Resident #435s physician orders reflected an order dated 7/8/24 Cleanse with NS & pat dry with gauze, then apply Betadine & LOTA. For both arms for dermatitis. Record review of pest control logs for the last three months revealed the facility was treated externally for mosquitos on 7/02/24 and would continue to be treated twice a month until October. No internal treatment was done. (continued on next page)

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	07/25/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview attempt on 7/25/24 at 2:21 PM with LVN-K was unsuccessful, phone call was not returned. Interview on 7/25/24 at 3:10 PM the Acting DON was not familiar with the mosquito situation (the DON was off on emergency leave). Interview on 7/25/24 at 3:40 PM the Administrator was not familiar with the mosquito situation, The Administrator stated he heard some residents might have been bitten but the DON addressed it. Interview on 7/25/24 at 4:00 PM the Maintenance Director stated he had been advised of mosquitos biting residents at night and the facility had been treated for mosquitos on 7/02/24. He stated the treatment was for the exterior as there were no chemicals that could be used inside the facility. He had observed the facility for mosquitos, especially the 200 Hall as it was where all the bitten residents were located, and he could not see any mosquitos currently. He would monitor, but it seemed like the issue was resolved. Interview on 7/25/24 at 3:10 PM The Administrator stated the facility had no policy covering pest control. This failure was identified as PNC deficient practice however, was corrected prior to the survey entry as of 07/02/24 per resident interviews.