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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675922 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER Parkview Manor Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 206 N Smith St Weimar, TX 78962 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page) |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 facility reviewed for physical environment. The facility failed to clean and/or remove ceiling tiles throughout the facility that had black, moldlike substance on them. This failure could place residents at risk for respiratory issues, infection, and hospitalization. Findings included: In an observation on 8/14/25 the following observations were made of a black, moldlike substance:- 10:23am: Ceiling tiles outside of the Soiled Utility room, across from room [ROOM NUMBER].- 10:31am: Ceiling tiles outside of room [ROOM NUMBER].- 10:33am: Ceiling tiles outside of room [ROOM NUMBER].- 10:35am: Ceiling tiles across from the entrance to the Therapy Gym.- 10:36am: Ceiling tiles over Nurse's Station 3.- 10:47am: Ceiling tiles in the Therapy Room. In an interview on 8/14/25 at 10:36 a.m., LVN W said they did not have a Maintenance Director at the moment and the last one left 2 weeks ago. She said the previous Maintenance Director would empty the air conditioner's drain pan regularly, that was in the attic. She said he would clean the mold with acid and bleach and then replace the tiles in the ceiling. She said he would also clean the walls with bleach/acid and then put new plaster over it and re-paint. LVN W said no one had done any repairs since he left. In an interview on 8/14/25 at 10:45 a.m., the ADM said, How do you know that is black mold, did you test it? after she was shown pictures of what was found. In an interview on 8/14/25 at 1:32 p.m., the ADM said they were making repairs as they were made aware. She said they had been fixing issues since the building was bought a year ago, but it took time to get everything done because it was an old building. She said she would have the maintenance people from some of the sister buildings come out and check the blackened areas on the tiles to see if they were mold. In an anonymous interview, it was said if the patch in room [ROOM NUMBER] was pulled back, black mold would be seen all over the beams and the Maintenance Director was told to spray bleach on it, patch the wall and paint it. The anonymous person said the ADM told the Maintenance Director; the smell of paint would cover the mold smell so the residents would stop complaining. The anonymous person said there was black mold everywhere, and the Maintenance Director spent his time bandaging the a/c system and replacing black mold tiles. The anonymous person said the drip pans from the a/c constantly got full and the pans had eroded away so much they were falling apart, causing the drains to clog from the particles and leak water into the ceiling, walls, and light fixtures. The anonymous person said the Maintenance Director was in the attic every day fixing the drains or the stains from the black mold. A policy on Physical Environment was requested and the ADM said they did not have one. Record review of the facility's policy on Resident Rights (no dates) read in part: The resident has a right to a dignified existence in an environment that promotes maintenance or enhancement of his or her quality of life. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care. The resident has a right to be treated with respect and dignity, including. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences .</p> | | |