STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675922	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor Nursing and Rehabilitation	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 7 residents (Resident #1) reviewed for abuse. The facility failed to ensure LVN A did not verbally and emotionally intimidate and abuse Resident #1 from 11/10/2025 through 03/04/2026, by speaking rudely to Resident #1, excluding the resident from smoke breaks, restricting Resident #1 from approaching or passing by the nurse's station, and removing Resident #1's smoking items from the nurse's station to keep Resident #1 from approaching the nurse's station. This failure could place residents at risk of abuse, and mental anguish and fearfulness. The findings were: Record review of Resident #1's face sheet dated 03/05/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included obstructive/chronic obstructive pulmonary disease (progressive lung condition that obstructs airflow, primarily caused by long-term exposure to irritants like cigarette smoke) with (acute) exacerbation, paraplegia (paralysis on half the body) status, muscle weakness, major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), nicotine dependence (a chronic brain disorder where tobacco use becomes compulsory, causing intense cravings, failed quit attempts, and severe withdrawal symptom), insomnia (difficulty falling asleep, staying asleep, or waking too early, resulting in poor sleep quality and daytime fatigue), dementia (brain disorders causing cognitive decline-memory loss, confusion, and behavioral changes that interfere with daily life) severity, without behavioral disturbance, and psychotic/anxiety/mood disturbance (disconnection from reality (hallucinations/delusions), often accompanied by severe anxiety and mood shifts (depression/mania), and dependence on wheelchair (an individual's reliance on a wheelchair for mobility due to physical, neurological, or musculoskeletal limitations). Record review of Resident #1's, undated, care plan reflected resident Focus: resident required antidepressant medication for diagnosis of depression date initiated 07/04/2024 and revised on 11/11/2025. Focus: Resident has impaired cognitive function or impaired thought processes due to dementia diagnosis as of initiated/revised date of 07/07/2025. Record review of Resident #1's care plan last updated 11/11/2025 reflected she was a smoker but had not reflected abuse allegations being made. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident had intact mental cognition. Record review of Resident #1's Progress Note dated, 11/10/2025 at 9:00 p.m. reflected LVN B witnessed an argument and heard LVN A telling Resident #1, You need to get off of my hall and go back down to your room right now. Resident #1 stated she could be down the hall if she wanted to be. LVN stated, I am not your nurse, and I want you off of my hall and don't comeback down here. Resident #1 voiced to LVN B that LVN A popped her in the mouth. LVN B performed a head-to-toe assessment. MD B was notified of incident on 11/10/2025 at 10:30 p.m. Intervention imitated by LVN B was to keep both parties involved in the incident apart. Other information noted LVN A notified the DON of incident. The progress note was reviewed and signed off on by the interim DON on (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Some	12/19/2025. Record review of Resident #1's skin assessment, dated 11/10/2025 at 09:30 p.m., reflected the resident's skin was intact, and no s/sx of skin integrity issues. Record review of Resident #1's trauma informed as needed assessment, dated 03/11/2026 at 07:01 p.m., reflected Resident #1 had not experienced any adverse effects from the 11/11/2025 abuse allegation. Record review of a complaint received to Health and Human Services, dated 03/03/2026, reflected LVN A had been very rude and verbally abusive toward Resident #1, had hid the resident's cigarettes, refused to take the resident out on schedule smoke breaks, and would tell the resident she was not allowed and could not come on the 300 hall (location of the nurse's station) which resulted in Resident #1 being scared of LVN A. In an interview on 03/05/2026 at 11:33 a.m., the administrator stated LVN A was terminated on 03/04/2026 after creating a hostile environment at the facility. He stated LVN A called the State Survey Agency on the facility as she was escorted out of the building as retaliation for her termination resulting in this State Survey visit. ADM stated his staff performed resident rounds everyday interviewing and checking on residents including Resident #1 and had not received any reports or complaints of physical, mental, or emotional distress related and felt the residents were safe. In an interview on 03/05/2026 at 3:09 p.m., the housekeeping supervisor stated LVN A began working at the facility in August of 2025, and lacked sincerity when working with the residents. She stated LVN A acted like her work with the facility was just a job and not a place to take care of residents. She stated LVN A was petty with the residents by telling them they could go home if they had not liked something LVN A and done or said. She stated after an allegation of abuse was reported by Resident #1 on 11/10/2025, which named LVN A, LVN A acted differently towards Resident #1 by not allowing the resident to join her for smoke breaks and disappeared becoming unlocatable when it was time to take Resident #1 out on smoke breaks. She stated she continued monitoring LVN A's behavior towards Resident #1 and reported the witnessed occurrences to the ADM. She stated thereafter, Resident #1 avoided LVN A by not going by the nurse's station when LVN A was on shift. Resident #1's family told her Resident #1 had once been a med aide who had worked with LVN A in the past at another facility. She stated that it had been her opinion that the facility had a hard time finding nurses who were willing to work and stay employed with the facility that it was more of a hinderance to lose a nurse than to deal with LVN A's behavior towards Resident #1. She stated the ADM was the facility's abuse coordinator and named the following as forms of abuse: physical, verbal, financial emotional, and sexual. In an interview on 03/05/2026 at 03:46 p.m., Med Aide stated that LVN A was tough as nails, direct, outspoken and bold. She stated that LVN A would not take Resident #1 out for cigarette breaks and LVN A stated that she did not fool with Resident #1 and Resident #1 did not fool (refusing to deal with or engage) with LVN A. She stated she was unaware of the reason for the discord between LVN A and Resident #1. She stated the ADM was the abuse coordinator and named the following as forms of abuse: physical, verbal, sexual, emotional, neglect, and financial. In an interview on 03/05/2026 at 04:45 p.m., director of respiratory therapy stated she witnessed on several occasions LVN A speaking rudely to Resident #1 and had refused and avoided taking Resident#1 out on smoke breaks. The DRT stated Resident #1 had to go a long way around the building to get through to the therapy department to avoid passing LVN A at the nurse's station on the 300-hall. She stated as the easiest route to the therapy department required passing by the nurse's station on the 300-hall. The DRT stated she had to inform Resident #1 not to interact with LVN A to avoid rude treatment and for the resident to direct her needs through the DRT when LVN A was on shift. The DRT stated the ADM and DON had been informed of LVN A's behavior towards Resident #1 several times during the facility's morning meetings and it was her understanding that the ADM and the DON had spoken to LVN A several times regarding her treatment towards Resident #1, but no changes occurred. DRT stated Resident #1 should not have had to avoid staff or any areas staff worked in to avoid rude treatment. She stated LVN A's negativity carried over onto the CNAs making a hostile environment for the staff. She stated the ADM was the abuse coordinator. In an interview on 03/05/2026 at 05:00 p.m., the director of dietary services stated LVN A had an awful character and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	would hide away making it difficult to find her for meal serving assistance during mealtimes. She stated LVN A was ugly to Resident #1 by denying her smoke breaks and speaking rudely towards the resident. She stated LVN A was a smoker and customary for the smoking staff to take the smoking residents out on breaks. She stated LVN A took several smoke breaks throughout the day but refused to take and/or allow Resident #1 to join her. She stated LVN A's treatment towards the resident began from the first day LVN A began working at the facility until LVN A's last day of employment with the facility. She stated LVN A was fired under the last ownership for poor performance and behavior, began working as an agency nurse at the facility, then had to be walked out when the facility learned she was on shift, and then hired again under the new/current ownership. She stated she was not sure if the new ADM and DON were aware of those occurrences. She stated on 02/27/2026, LVN A spoke loudly and rudely to the ADM and threatened to have someone whoop (inflict physical harm) the ADM which resulted in the employment termination of LVN A. She stated that the ADM was the abuse coordinator for which all allegations of abuse: verbal, physical, sexual, financial, and emotional were reported. She stated the ADM and DON were made aware of LVN A's treatment towards Resident #1, but she stated that she had not seen any changes. In an interview on 03/05/2026 at 05:23 p.m., the DON stated a week prior she had to provide LVN A with a written disciplinary counseling about toning down her attitude, and unprofessional behavior and interactions with the staff. The DON stated she had to redirect LVN A who told Resident #1 she could not drive her motor wheelchair around the nurse's station as LVN A did not want the resident around her after an unsubstantiated abuse allegation on 11/10/2025. She stated Resident #1 had not expressed any concerns since the abuse allegation but could see the energy was different with Resident #1 when LVN A was on shift. She stated therefore they moved Resident #1's cigarettes that had once been stored at the nurses' station to the memory care unit to help Resident #1 avoid LVN A. She stated she felt that was the best course of action to reduce any adverse effects of Resident #1's interactions with LVN A. She stated the ADM was the abuse coordinator and the facility provided ANE in-services monthly and as needed. In an interview on 03/05/2026 at 6:09 p.m., Resident #1 stated she had to avoid going to the nurse's station when LVN A was on shift otherwise LVN A would stop her, grab her electric controller and turn her around. She stated LVN A also refused to take her out on smoke breaks and her cigarettes had to be moved from the nurse's station on the 300-hall because LVN A had not wanted them there. She stated the quickest route to therapy was past the nurse's station on the 300-hall, but when LVN A was on shift, she had to go a longer route to get to therapy to avoid LVN A. She stated LVN A's negative behavior towards her began in November of 2025 when LVN A slapped her in the mouth and she reported the incident to the ADM. She stated at first LVN A's treatment made her feel bad and sad and she would sit at the window watching LVN A and the other resident smoke during smoke breaks she could not go on. She stated another staff had always taken her out thereafter, and other staff and residents encouraged her not to feel bad, but it took a while and took DRT telling her not to listen or pay attention to LVN A's behavior towards her. She stated after a while LVN A's behavior began not to bother her anymore and she adjusted to avoid contact, communication and proximity of LVN A when she was on shift. She stated the ADM was the facility's abuse coordinator. In an interview on 03/11/2026 at 11:13 a.m., the ADM stated there had not been an active social worker on staff with the facility for the last 30-day s or so to ask about Resident #1's psychosocial status since the abuse allegation was made. The ADM stated he was the acting SW until a new hire filled the position. He stated the abuse allegation made against LVN A by Resident #1 on 11/10/2025, was reported to the State Survey Agency in November 2025, investigated and both the facility and the State Surveyor at that time found the allegations to be unsubstantiated. He stated that the facility social worker who no longer works for the facility and himself checked in on Resident #1's psychosocial status after the incident and found that she had no emotional or mental issues as a result of the allegation. He stated no further incidents were reported to him regarding LVN A's treatment or interactions with or towards Resident #1. In an interview on 03/11/2026 at 12:10 p.m., (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	the HS stated LVN A intimidated Resident #1 from the time LVN A began working at the facility by making rude comments to her and restricting her from going near the nurse's station when LVN A was on shift, and making Resident #1 scared to go around LVN A. She stated LVN A would not take Resident #1 out on smoke breaks and expressed Resident #1 was not allowed to come down the hall near the nurse's station when LVN A was on shift. The HS stated she had to take the resident out on smoke breaks as a result. She stated at first, she asked Resident #1 why she was not going down the hall near the nurse's station and Resident #1 would say she was not going anywhere near LVN A, refusing to use LVN A's name. She stated she spoke to Resident #1 about how it made her feel and the resident told her she had not wanted to get anyone in trouble so she would avoid the nurse's station. She told the residents not to worry about getting anyone in trouble. She stated Resident #1 would ride all the way around the other side of the facility to get to an area that was easily accessible by just passing the nurse's station to avoid LVN A. She stated Resident #1's cigarettes had to be removed from the nurse's station to the memory care nurse's station because LVN A made a big deal about them being at the nurse's station and not wanting them there. She stated LVN A was a smoker, would take the other facility's smoking resident out on smoke breaks, but not Resident #1 making another staff have to come off the floor to take Resident #1 out after LVN A finished. She stated it had was discussed in the morning meeting and it had not made sense to have two smoke break times because of LVN A's discontent. She stated nevertheless, two smoke times were initiated. She stated the ADM was the abuse coordinator and named the following as forms of abuse: physical, verbal, sexual, emotional, neglect, and financial. She stated the facility provided ANE in-services monthly and as needed. In an interview on 03/11/2026 at 01:05 p.m., CNA A stated she was aware that LVN A could not get along with Resident #1 but could not provide any specific details or incidents as to why. She stated the ADM was the facility's abuse coordinator and listed the following as forms of abuse: financial, verbal, mental, physical, and sexual. She stated she received her last in-service on ANE on this date. In an interview on 03/11/2026 at 02:56 p.m., the interim DON stated LVN B witnessing LVN A tell Resident #1 as noted in the progress note dated 11/10/2025 at 9:00 p.m. stating Get off my hall and go back down to your room right now was not enough evidence to substantiate any forms of abuse against LVN A. He stated that the ADM was the abuse coordinator who ensured the facility received in-service training on ANE at least monthly but also as needed. In an interview on 03/12/2026 at 12:28 p.m., the ADM stated he was the abuse coordinator and had was notified on 11/11/2025 by the facility's corporate office that Resident #1 made an abuse allegation against LVN A. He stated Resident #1 stated LVN A popped her in the mouth. He stated the facility immediately suspended LVN A at that time and conducted an investigation finding no witnesses to collaborate with the allegations and he had to unsubstantiate the findings. He stated after he was not made aware by the resident or any staff, Resident #1 had issues with LVN A, which intimidated her after the allegations was made. In an interview attempt on 03/13/2026 at 11:28 a.m., the MD left a voicemail message for a return call. No interview was obtained. Record review of ANE in-service training dated 11/11/2025 reflected LVN A signed off on receiving this in-service. Record review of LVN A's employee disciplinary report reflected an infraction that occurred on 02/28/2026 where LVN A created a hostile work environment by behaving in an unprofessional manner towards the ADM. LVN A was terminated effective immediately signed by DON on 03/04/2026. LVN A refused to sign off on the report. Record review of resident-to-resident incidents in-service training dated 03/10/2026 reflected incidents were to be reported to the ADM for investigation. LVN A had not signed off on receiving this in-service. Record review of the facility's, undated, policy titled Abuse/Neglect reflected Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a resident who was transferred or discharged had complete and accurate documentation in their clinical records, including required information to support continuity of care for closed record one of 4 residents (CR) reviewed for transfer-discharge. The facility failed to ensure CR's transfer/discharge documentation was completed in a timely manner. This failure had the potential to affect all residents requiring transfer or discharge by increasing the risk of miscommunication, gaps in care, and adverse outcomes. Findings included:Record review of CR's face sheet dated 03/05/2026 reflected an [AGE] year-old female who admitted to the facility on [DATE] with no discharge date noted. CR had diagnoses which included depressive episodes (cause significant distress or impairment but do not meet the full criteria), gastro-esophageal reflux disease without esophagitis (experience chronic heartburn and reflux symptoms), anemia (blood disorder where the body lacks enough healthy red blood cells or hemoglobin, leading to reduced oxygen flow to organs), insomnia, (difficulty falling asleep, staying asleep, or waking too early, resulting in poor sleep quality and daytime fatigue), hyperkalemia (high blood potassium levels that can cause dangerous heart arrhythmias or sudden cardiac arrest), and diaphragmatic hernia (an abnormal opening in the diaphragm allowing abdominal organs (stomach, intestines) to move into the chest cavity without strangulation or tissue death) without obstruction or gangrene (death of body tissue caused by infection or lack of blood flow). Record review of CR's undated, care plan reflected resident CR had dementia problems with communication, and unclear speech, with an ADL self-care performance deficit, and had limited physical mobility, and received antidepressant medication with adverse risks of side effects and reactions. Record review of CR's Quarterly MDS, dated [DATE], reflected, CR had a BIMS score of 04 indicating that CR had mentally impaired cognition. In an interview on 03/05/2026 at 06:42 p.m., Family #1 stated she received a call on 03/04/2025 from LVN A who stated CR #1 was sent to the hospital ER for stroke like symptoms. She stated LVN A reported that the CR had been having s/sx of stroke for the last 24-hours, but nobody informed Family #1. She stated that on 03/05/2026, LVN A told her LVN A went against the facility protocol on 03/04/2026 and called 911 to send CR #1 out for medical attention. She stated LVN A told her she checked on CR at the end of her shift on 03/02/2026 and told the on-coming LVN B to monitor CR for stroke like symptoms. She stated LVN A was off on 03/03/2026 and returned on 03/04/2026 finding that CR's condition had worsened. She stated based on this information a complaint was made to HHSC. She stated on 03/04/2026 it was determined by the hospital CR had a stroke and was med-flight to higher level of care hospital. She stated LVN A later called and stated that LVN A was fired as a result of calling 911 and sending CR out without prior physician consent. She stated at this time she had not received an official call from the facility informing her that the CR had a change in condition nor had anyone from the facility called to check on the CR's status. She stated the hospital physician stated CR would probably not wake up, and if she had, would be paralyzed on her left side and would never speak again. She stated the hospital physician had advised her to consider placing CR on hospice care. In an interview on 03/11/2026 at 12:10 p.m., the HS stated on 03/04/2026 she was not on shift when CR was discharged . She stated on 03/04/2026, LVN A called her informing her of the CR's discharge and how the Med Aid observed CR in and out of consciousness on 03/03/2026 during the first shift. She stated she told LVN A that it could not have been possible for CR to be unconscious throughout both shifts without any nursing staff checking on CR. In an interview on 03/11/2026 at 12:34 p.m., LVN C stated on 03/04/2026 she was off shift and received a call from the DON asking about CR's LVN A discharging CR to the hospital that morning. She stated she told the DON that at the end of her shift on 03/03/2026 Med Aid came to her and stated that Family 2 had concerns that CR was not feeling well. She stated she went to assess CR (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and found that CR's vitals were fine, and CR was able to state she was fine. She stated she had not spoken to Family 2 about CR status at that time. She stated that LVN D came on shift to relieve her, and she informed LVN D to watch for any changes in CR's condition. She stated she was not aware that CR's clinical chart had no notes of discharge to the hospital. She stated since LVN A was CR's nurse, it would have been LVN A's responsibility to complete CR's discharge documentation summarizing the reason for the discharge, and how CR left the facility. She stated that LVN A had not completed the required discharge documents. In an interview on 03/11/2026 at 02:25 p.m., the Med Aid stated since CR's discharge, she had not seen any clinical notes in CR's records reflecting CR's reason for being sent out of the facility. She stated she would have expected LVN A to complete CR discharge documentation prior to LVN A ending LVN A's shift. In an interview on 03/11/2026 at 02:56 p.m., the interim DON stated on 03/04/2026, the CR was found to have a change of condition that required her immediate transfer by ambulance to a higher level of care facility. He stated as CR's nurse, after completing a physical assessment, SBAR report summarizing CR change of condition that required the ER transfer to a higher level care facility, LVN A should have completed a discharge summary for CR's discharge to reflect on the ADT list required by CMS. He stated LVN A had not completed the SBAR which was unable to trigger the discharge summary report and effected CR's discharge from reflection on the ADT report within the following 24-hours of CR's discharge. He stated that because of LVN A's failure to complete CR's discharge documentation, there were no notes reflecting CR's physician and family contacts or the status of CR's location and current condition. He stated CR's discharge documentation was important for the continuity of CR's care. In an interview on 03/12/2026 at 12:28 p.m., the ADM stated he learned CR discharged CR's hospital on [DATE]. He stated he asked LVN A why the resident was sent out and LVN A stated due to a change in condition. He stated he attempted to get more information from LVN A who was CR's charge nurse and the nurse who discharged CR to the hospital, with no response. He stated on 03/05/2026 Family #3 requested CR's clinical records, but he stated he had provided Family #3 with only the last hospital notes documented in CR's progress notes because he wanted to find out more from his staff the reason for CR's discharge before he released the information. He stated that LVN A had not completed the required change of condition/SBAR documentation that triggered and initiated the discharged documentation as to when, where, and why CR was sent to the hospital to date resulting. He stated charge nurses were responsible for completing a SBAR, skin, and pain assessment in preparation of a resident's discharge out of the facility. He stated failure to complete those assessments resulted in untimely information being reported to CMS. He stated LVN A was terminated on 03/04/2026 at 3:00 p.m. for unrelated issues. In an interview on 03/13/2026 at 02:14 pm., MD B stated on 03/04/2026 at 03:29 p.m., she received a call from LVN A reported CR's eyes were rolling in the back of head and her blood pressure was elevated. MD B directed LVN A send CR out for immediate transfer to the hospital due to stroke like symptoms. Record review of the facility's ADT log, dated 03/04/2026 - 03/11/2025, reflected CR discharged to an acute care hospital on [DATE]. Record review of CR's Discharge summary dated after survey intervention on 03/11/2026 at 08:56 p.m. and signed and completed by interim DON, reflected CR admitted to the facility on [DATE] and was discharged to the hospital on [DATE], due to a change in condition on 03/04/2026.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with professional standards of practice for 1 of 3 residents (Resident #1) reviewed for quality of care. The facility failed to complete a psychosocial assessment after Resident #1 alleged physical abuse. This failure could place residents at risk for potential injuries, physical and/or emotional pain, and hospitalization. The findings included:Record review of Resident #1's face sheet dated 03/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included paraplegia (paralysis on half the body) status, (progressive lung condition that obstructs airflow, primarily caused by long-term exposure to irritants like cigarette smoke) with (acute) exacerbation, major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), dementia (brain disorders causing cognitive decline-memory loss, confusion, and behavioral changes that interfere with daily life) severity, and psychotic/anxiety/mood disturbance (disconnection from reality (hallucinations/delusions), often accompanied by severe anxiety and mood shifts (depression/mania), and nicotine dependence (a chronic brain disorder where tobacco use becomes compulsory, causing intense cravings, failed quit attempts, and severe withdrawal symptom). Record review of Resident #1's, undated, care plan reflected resident Focus: Resident has impaired cognitive function or impaired thought processes due to dementia diagnosis as of initiated/revised date of 07/07/2025. Focus: Resident required antidepressant medication for diagnosis of depression date initiated 07/04/2024 and revision on 11/11/2025. Resident #1's care plan had no reflection of an abuse allegation. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated the resident had intact mental cognition. Record review of Resident #1's nursing note, completed by LVN A, dated 11/10/2025 at 07:15 a.m., reflected Resident #1 had a verbal behavior/altercation, while being mentally oriented with no injuries. The behavior/altercation reflected: while escorting Resident #1 out on a smoke break, Resident #1 verbalized being upset the smoke break was late. LVN A informed CR that other assignments had to be completed and when those assignments were complete, LVN A provided Resident #1 with her smoke break. CR began making insulting comments and calling LVN A an nigger bitch,. LVN A requested LVN B take resident out for her smoke break as a result of the behavior at that time as well as during the 3p.m. smoke break that same day. The SW was made aware of CR's behavior. The interim DON signed off on the nurses note dated 12/18/2025. Record review of Resident #1's nursing note, completed by LVN B, dated 11/10/2025 at 09:00 p.m., reflected the resident had a cognition/behavior/agitation event in the hallway when asked about the television LVN A began yelling while on the 300-hall to Resident #1, You need to get off of my hall and go back down to your room right now. Resident stated she could be down the hall if she wanted to be. LVN A stated, I am not your nurse, and I want you off of my hall and don't come back down here. Arguing started and Resident #1 and LVN A went their separate ways with no injuries or pain noted. No s/sx resident had distress/discomfort at time of observed incident. Record review of Resident #1's nursing note, completed by DON, dated 11/10/2025 at 9:30 p.m., reflected: Treatment/New Orders: After occurrence and information Resident #1 voiced LVN A popped her in the mouth. The DON performed a head to toe assessment and informed Resident #1's responsible party (RP), MD B on 11/10/2025 at 9:30 p.m. Intervention: Keep both parties involved in this incident apart. Interim DON signed off on the nurses note dated 12/19/2025 at 11:38 a.m. Record review of Resident #1's nursing note, completed by LVN B dated 11/10/2025 at 09:30 p.m., reflected no adverse skin issues. MD B was informed of CR's weekly skin assessment on 11/12/2025. Record review of Resident #1's nursing note completed by LVN B, dated 11/10/2025 at 09:30 p.m., reflected the resident had a patterned verbal behavior with (continued on next page)

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	675922	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor Nursing and Rehabilitation	206 N Smith St Weimar, TX 78962

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no adverse mental, emotional, or physical effects. In an interview on 03/11/2026 at 02:56 p.m., the interim DON stated LVN B documented a nursing progress note, dated 11/10/2025 at 9:00 p.m. reflecting that Resident #1 made an allegation that LVN A had popped the resident in the mouth. He stated that neither during nor after the allegations were investigated, had the facility performed a follow-up psychosocial assessment for Resident #1. He stated the importance of a psychosocial assessment was to ensure the resident had not experienced any psychological harm from the event. He stated there were also no risk assessments conducted after the incident. He stated on 03/11/2026 he completed a trauma assessment interview with Resident #1 had expressed no risks other than falls related to the allegation. In an interview on 03/12/2026, at 12:28 p.m., the ADM stated he was unaware the facility had not completed a psychosocial evaluation to ensure Resident #1 had not experienced any adverse effects from her abuse allegation on 11/11/2025. He stated it had been his expectation that the facility's social worker (SW) who was no longer with the facility would have been responsible for initiating that evaluation but was unaware why it had not been. He stated Resident #1 had not expressed to him or any other staff she had issues with LVN A after 11/11/2025. He stated LVN A received disciplinary actions prior to her termination on 03/04/2026, but they were related to her professionalism with and towards staff not residents. Record review of facility's, undated, policy titled Behavior Management Policy reflected: Policy: Behavior management includes the management of anger, confusion, hallucinations, and other behavior by utilizing techniques such as area limitations, self-responsibility, group interactions, limit setting, and behavior modifications depending on individual needs. Behavior changes can be attributed to dementia disorders or psychological conflicts resulting from a loss of control over body, environment, and unmet needs such as pain, hunger, thirst, and toileting. They may include combativeness, arguing, agitation, and aggressiveness. Goals1. The resident will modify behavior for optimal functioning and well-being.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to maintain complete and accurate clinical records for resident accordance with professional standards and regulatory requirements for closed record one of 4 residents (CR) reviewed for assessments. The facility failed to complete an incident report reflecting the resident's current condition and care provided after CR had a change in condition which resulted in a hospitalization. This failure had the potential to affect all residents residing in the facility by compromising continuity of care, clinical decision-making, and resident safety. Findings included:Record review of CR's face sheet dated 03/05/2026 reflected an [AGE] year-old female who admitted to the facility on [DATE] with no discharge date noted. Cr had diagnoses which included muscle wasting and atrophy (loss of muscle tissue, causing muscle thinning, weakness, and reduced mobility), other abnormalities of gait and mobility (irregular walking patterns caused by pain, neurological diseases, or musculoskeletal issues, including limping, shuffling, or instability), muscle weakness, dementia (brain disorders causing cognitive decline-memory loss, confusion, and behavioral changes that interfere with daily life), without behavioral/psychotic/mood/anxiety disorders (disconnection from reality, hallucinations/delusions). Record review of CR's undated, care plan reflected resident Focus: CR had an ADL self-care performance deficit, communication, problems with unclear speech and Dementia, but was usually understood and usually understands, limited physical mobility, required antidepressant medication with the risk for side effects/adverse reactions. Record review of CR's Quarterly MDS, dated [DATE], reflected a BIMS score of 04 indicating that CR had impaired mental cognition. In an interview on 03/05/2026 at 06:42 p.m. Family #1 stated she received a call on 03/04/2025 from LVN A who stated CR had stroke like symptoms and was sent to the hospital ER. She stated on 03/04/2026 it was determined by the hospital CR had a stroke and was med-flight to higher level of care hospital. She stated LVN A reported to the facility on [DATE] prior to coming off shift that the CR had been having s/sx of stroke for the last 24-hours, but nobody informed Family #1. She stated that on 03/05/2026, LVN A called and told her when LVN A left shift on 03/02/2026 LVN A told LVN B, the on-coming nurse to monitor CR for stroke like symptoms as she had concerns. She stated LVN A told her she was off shift on 03/03/2026 and returned on 03/04/2026 finding that CR's condition had worsened. She stated at that time, LVN A told her LVN A went against the facility protocol and called 911 to send CR to the ER. She stated LVN A told her LVN A was fired for calling 911 and sending CR to the ER without prior MD consent. She stated based on this information a complaint was made to HHSC. She stated at this time she had not received an official call from the facility informing her that the CR had been discharged with a change in condition nor had anyone from the facility called to check on the CR's status. She stated the higher level of care hospital physician stated CR would probably not wake up, not speak again, and would be paralyzed on her left side. She stated at this time, CR's MD had advised her to consider placing CR with hospice care. In an interview on 03/11/2026 at 12:10 p.m., the HS stated she was not on shift when CR was discharged . She stated on 03/04/2026, she received a call from LVN A informing her CR's discharged and how the Med Aid observed CR in and out of consciousness during the first shift on 03/03/2026. She stated she told LVN A that it could not have been possible for CR to be unconscious throughout both shifts without any nursing/CNAs reporting CR had a change in condition. In an interview on 03/11/2026 at 12:34 p.m., LVN C stated she was off shift on 03/04/2026 when she received a call from the DON asking about CR's change of condition resulting in LVN A discharging CR that morning. She stated on 03/03/2026 the Med Aid came to her and stated that Family 2 had concerns that CR was not feeling well. She stated she assessed CR and found that CR's vitals were fine, and CR stated she was fine. She stated she had not spoken to Family 2 about CR status at that time. She stated that LVN D relieved her shift, and she informed LVN D to watch for any changes in (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CR's condition. She sated she relayed all this information to the DON during the call. She stated she was not aware that CR's clinical chart had not reflected CR's change of condition on 03/04/2026. She stated LVN A was CR's nurse, and LVN A's responsibility to update and complete CR's change of condition documentation to outline CR's changes, vital signs, MD and RP notification, and subsequence MD orders. She stated that LVN A had not completed the change of condition documents. In an interview on 03/11/2026 at 01:05 p.m., CNA A stated she worked with the CR on 03/03/2026 from 6:00 a.m. - 6:00 p.m. She stated she had changed CR's bed linen, gave her a bed bath, changed her clothing, and brushed CR's hair. She stated the CR had no desire to eat her breakfast meal that morning, which was not abnormal, but accepted and ate her lunch meal, at 2:00 p.m. she laid CR down in her bed for the day. She stated she was off on 03/04/2026 she returned to shift on 03/05/2026, and CR was no longer at the facility. In an interview on 03/11/2026 at 02:25 p.m., the Med Aid stated on 03/03/2026 at 5:00 p.m. she attempted to pass medication to CR while Family #2 was in CR's room ensuring CR ate her dinner on that day, as he often had. She stated CR was asleep and she was unable to pass the medication to CR. She stated before she left the room Family #2 stated he did not like the way CR was looking. She stated she noticed CR appeared to be sleeping, when was not abnormal, but she could see the whites of her eyes showing a bit. She stated she had actually never seen CR's full face while she was asleep because CR always had her hair bonnet pulled down over most of her face when she slept and Med Aid was unaware if that was normal for CR's eyes to look that way. She stated she then asked CNA C how CR looked when she was last checked on and CNA C said CR was fine. She stated then she informed LVN C who was standing by and overheard her speaking to CNA C that CR had not received her medications because she was asleep. She stated LVN C was coming off shift as well, and LVN C informed LVN D who was coming on shift of CR's missed medications. She stated rumor was Family #2 spoke to LVN C about CR's condition, but no one came to check on CR for 12-hours and when LVN A came on shift the morning of 03/04/2026, LVN A found CR's blood pressure at 181/131 which was high and indicated CR was in distress. She stated therefore LVN A called 911 and sent CR out for higher level of care. She stated since CR's discharge, she had not seen and documented nursing notes reflecting what the s/sx CR exhibited or the reasoning for CR being sent out of the facility. She stated she would have expected LVN A to complete documentation to note CR's discharge. In an interview on 03/11/2026 at 02:56 p.m., the interim DON stated on 03/04/2026, the CR was found to have a change of condition that required her immediate transfer by ambulance to a higher level of care facility. He stated as CR's nurse, LVN A should have completed a Sbar (change of condition report) after completing a physical assessment on CR noting the date, time, and details of CR's change in condition that required the emergency transfer to a higher level care facility. He stated the report would have also included CR's vitals at the time of transfer, medications, and notification to CR's MD and her family. He stated as of this date, there was no Sbar, discharge summary, or nursing progress notes detailing or summarizing CR's need for hospital transfer or her condition for transfer to the hospital on [DATE] and he could not say why. He stated failure to complete the SBAR also effected CR showing up on the ADT list and initiating the discharge summary which was required by CMS. He stated it was the DON's responsibility to ensure that the charge nurse/LVN A completed the SBAR. He stated the process had fallen through and the discharge was not reviewed. He stated that based on CR's clinical records, there was no documentation the CR's physician and family were contacted about her discharge and documenting such was important for the continuity of CR's care, so they were to be aware of CR's location and current condition. In an interview on 03/12/2026 at 12:28 p.m., the ADM stated he learned of CR's change of condition hospital discharge on [DATE] and asked LVN A why the resident was sent out. He stated LVN A told him CR had a change of condition. He stated he then spoke to Med Aid who told him that on 03/04/2026, CR had seemed more sleepy than normal. He stated she spoke to LVN C and LVN D who both stated they had not noted anything wrong with CR when they last worked with her on 03/03/2026 into the morning of 03/04/2026. He stated then on 03/05/2026 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family #3 came in and asked for CR's clinical records. He stated he provided Family #3 with only the last hospital notes noted in CR's progress notes and Family #3 requested more details, which he stated he had not provided Family #3 because he wanted to find out from his staff what occurred with CR before he released the information. He stated he attempted to get more information from LVN A who was CR's charge nurse and the nurse who sent CR to the hospital, with no response. He stated in the evening of 03/05/2026 Family #3 came to the facility with a truck to retrieve all of CR's personal belongings. He stated that LVN A had not completed the required change of condition/SBAR documentation as to when, where, and why CR was sent to the hospital to date. He stated LVN A was terminated on 03/04/2026 at 3:00 p.m. for an unrelated issue. He stated charge nurses should be completing a SBAR, skin, and pain assessment at the time when a resident prepared to discharge out of the facility. He stated failure to complete those assessments resulted in untimely information being reported to CMS. In an interview on 03/12/2026 at 03:11 p.m., CNA B stated she worked the evening shift and on 03/03/2026 into 03/04/2026 and had not noticed any changes in condition in CR. In an interview on 03/12/2026 at 03:13 p.m., CNA C stated she had cared for CR on many occasions overnight and was familiar with CR's baseline. She stated on 03/03/2026 into 03/04/2026 she had not noticed any changes in condition that required her to inform CR's nurse. She stated she last saw CR on 03/04/2026 at 5:00 a.m. when providing CR incontinent care, as CR was wet and CR thanked her for the brief change. She stated CR was normally like that and had not looked sick. She stated CR was sleepy but that was normal because she cared for CR throughout the night shift. She stated she had no reports to share with LVN D related to a change in condition. In an interview on 03/13/2026 at 02:14 pm., MD B stated on 03/04/2026 at 03:29 p.m., LVN A called to inform her that while at the facility CR's eyes were rolling in the back of head and her blood pressure was elevated. MD B directed LVN A to call 911 to have CR immediately transferred to the hospital and CR was med-flight to the hospital due to stroke like symptoms. Record review of CR's physician note dated 03/03/2026 at 09:55 a.m., reflected PA-C assessed CR noting no issues and continue to report any s/sx of issues. Record review of CR's March 2026 MAR reflected the CR received her doses of medication on 03/02/2026 and were administered by the Med Aid. Record review of the facility's admissions, transfer, discharges log, dated 03/04/2026 - 03/11/2025, reflected on 03/04/2026 CR discharged to an acute care hospital. Record review of CR's discharge summary date on 03/11/2026 at 08:56 p.m., after survey intervention reflected CR admitted to the facility on [DATE] and was discharged to the ER on [DATE] due to a change in condition on 03/04/2026 signed and completed on 03/11/2026 by interim DON.