

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 09/05/2025
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident 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 describing services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Resident #18) reviewed for comprehensive care plans. 1. The facility failed to care plan Resident #18's behavior of entering male residents' rooms and taking off her clothes. This failure could lead to residents not having their individual, medical, functional, and psychosocial needs identified and cause a physical, mental or psychosocial decline in healthRecord review of Resident #18's face sheet dated 09/05/2025, she was a [AGE] year-old female originally admitted to the facility on [DATE]. Her medical diagnoses included Alzheimer's Disease (a progressive disease affecting memory loss and decline in cognitive abilities), Type 2 diabetes mellitus (high blood sugar), and anxiety disorder (a mental health condition characterized by excessive fear, worry, or dread that interferes with daily life). Record review of Resident #18's Quarterly MDS dated [DATE] reflected a BIMS (short interview to measure cognition) score of 3, indicating severe cognitive impairment. Resident #18 was able to independently ambulate and dress. Record review of Resident #18's progress notes revealed the following behaviors:-3/30/2025 at 5:34pm, Resident #18 was going into other residents' rooms and removing their linen and pillows, she was redirected. -6/16/2025 at 9:11am, Resident #18 was redirected on two occasions from male rooms where she went into rooms and started removing clothes. The resident did not like being taken out but did leave. -7/19/2025 at 5:35pm, Resident #18 continued to remove clothing and was redirected and staff re-dressed her as needed.-8/7/2025 at 3:09pm, Resident #18 was walking in and out of other residents' rooms and taking off her clothes, and she was redirected every 10-15 minutes of that behavior.[Record review of Resident #18's care plan last captured 09/04/2025, revealed she was not care-planned for behaviors of entering male residents' rooms and taking off her clothes. Record review of Resident #18's monthly psychological assessments from March 2025 to August 2025, revealed there were no concerns related to the resident's wellbeing. Observation and interview with Resident #18 on 9/2/2025 at 7:40pm, she stated she liked her sisters and the people that helped her at the facility. Resident #18 was lying in bed, sleeping on her sheets. There were no odors or clutter in Resident #18's room. Interview with LVN C on 9/2/2025 at 7:50pm, she said Resident #18 walked around during the daytime and would take her clothes off in the common areas and Resident #18 had to be redirected. LVN C said the nurses' station was in the center of the unit and they can monitor all residents. Interview with MA P on 9/4/2025 at 11:30am, she said Resident #18 used to be aggressive but had calmed down. Resident #18 had habits of wandering room to room., stripping beds, and undressing herself. Staff knew to redirect Resident #18 out of residents' rooms and getting her to put her clothes back on by offering activities or snacks . MA P said she always redirect the Resident #18. Interview with MDS A on 9/4/2025 at 2:40pm, she said she was in charge of completing resident care plans. MDS A was aware (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18 had behaviors of taking off her clothes and going to male residents' rooms. MDS A said the purpose of care plans was so staff could get a better picture of residents' care, and if behaviors were not care-planned, then staff would not know how to fully take care of residents. Interview with the Administrator on 9/5/2025 at 11:13pm, the Administrator said Resident #18's behaviors should have been in her care plan and the care plan gave staff a snapshot of how to take care of residents and were basic instructions on providing care. Care plans were a way for staff to communicate about residents as well. If care plans did not capture a resident's total care, it could put the residents at risk. The Administrator said that MDS A and the MDS Nurse in general were in charge of documenting, but that care planning started with the nurse who was responsible for communicating resident's care with the MDS Nurse. Record review of the facility's Comprehensive Care Plan Nursing Policy and Procedure Manual, undated, revealed in part, Care plans will be person-centered and reflect the resident's goal of admission and desired outcomes .The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.		

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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** Based on observations, interviews, and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for two (Resident #15 and Resident #26) of 4 residents reviewed for medication administration. -Resident #15 was given Midodrine for her hypotension (low blood pressure) outside of prescribed parameters on 8/4/2025 at 10:00am and 6:00pm, 8/10/2025 at 10:00am and 8/28/2025 at 10:00am. -Resident #26 was given Carvedilol for his hypotension outside of prescribed parameters on 8/4/2025 at 9:00amThese failures placed residents at risk of not receiving medications as prescribed, decreased therapeutic effects of the medications, risk for drug diversion, delay in medication administration and worsening of their medical conditions.Resident #15Record review of Resident #15's face sheet last captured 09/05/2025, she was a [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses included: metabolic encephalopathy (a brain dysfunction caused by an underlying condition, and could affect mood, thinking, memory or loss of consciousness), Major Depressive Disorder (prolonged sadness which can cause a loss of interest and withdrawal from familiar activities), dementia (loss of cognitive functioning like thinking, reasoning and memory and potential loss of emotional control and personality) and hypotension (low blood pressure). Record review of Resident #15's Quarterly MDS dated [DATE], she had a BIMS score of 00, indicating severe cognitive impairment. Resident #15 required moderate assistance with ADLs like toileting, eating and personal and oral hygiene and was coded as always incontinent of urine and bowel. Record review of Resident #15's care plan last captured 09/05/2025, she was care-planned for adverse medication effect and behavior monitoring initiated 06/09/2025, with interventions including monitoring and accurate documentation of the resident's response to any treatment such as vital signs, progress notes and medication administration records. Record review of Resident #15's Order Summary report captured 09/05/2025, revealed Resident #15 had an order for Midodrine HCl oral Tablet 5 MG, give 1 tablet by mouth two times a day for symptomatic orthostatic hypotension[when your blood pressure drops suddenly after standing up from a sitting or lying down , causing one to feel dizzy, lightheaded or even faint), hold for SBP <130 (< less than) with a start date of 04/17/2025 . Record review of Resident #15's MAR reflected Resident #15 was given Midodrine HCl oral Tablet 5 MG, give 1 tablet by mouth on 8/4/2025 at 10:00am and 6:00pm, 8/10/2025 at 10:00am and 8/28/2025 at 10:00am, when it was supposed to be held if SBP <130. Observation and attempted interview on 9/3/2025 at 7:52am with Resident #15, revealed she was lying in bed, and appeared in a pleasant mood. Resident #15 was unable to answer questions.Resident #26 Record review of Resident #26's face sheet dated 09/05/2025 reflected a [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE]. His medical diagnoses included chronic venous hypertension (high blood pressure in the veins of the legs), orthostatic hypotension (when someone's blood pressure drops when they are standing up or sitting down), and history of falling. Record review of Resident #26's Comprehensive MDS dated [DATE], revealed he had a BIMS score of 15, indicating high cognitive intactness related to thinking and memory. Record review of Resident #26's care plan last captured 09/05/2025, he was care-planned for having heart failure, hypertension with interventions including monitoring for side effects such as orthostatic hypotension. Record review of Resident #26's Order Summary captured 09/05/2025, revealed he was prescribed Carvedilol Tablet 3.125 MG, give 1 tablet by mouth two times a day for heart failure and hold if SBP less than 100 with a start date of 04/15/2025.Record review of Resident #26's August 2025 MAR revealed he had a blood pressure reading of 93/57 on 08/04/2025 and was given Carvedilol on 08/04/2025 at 9:00am . Record review of Resident #26's progress notes for August 2025, revealed there were no nurses' notes or documentation on Resident #26 taking (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Carvedilol outside of the parameters. Interview with MA P on 09/04/2025 at 11:30am, she said that she would tell the nurse on duty about residents' vitals that were out of parameter, and the nurse would let MA P know whether to give the medication or not. LVN Z would do vitals and then MA P would come in and give the medications. MA P did not document telling LVN Z about the vitals but said she did inform LVN Z. Interview with LVN Z on 09/05/2025 at 1:51pm, she said she was not informed about Resident #15's SBP being over 130 and that she should have been notified of the vitals out of parameters. She said that if aides told her about vitals out of parameters LVN Z would review the vitals and re-check resident's vitals again. Resident #15 and Resident #26 had no issue of low blood pressure but that could have happened if they were given her blood pressure medication out of parameters. LVN Z said aides were good about reporting vitals for Resident #26 and that LVN Z checked vitals throughout the day as well. Interview with the DON on 9/5/2025 at 2:27pm, she said that MAs should notify nurses when resident vitals were out of parameters. The MA did not give Resident #26's medications as ordered. If Resident #15's and #26's medications were given when vitals were out of parameters, it could cause the vitals to be increased even more beyond range. The MAs were trained by the DON to give medications, and it would be part of their certificate. The DON said nurses were to document vitals MAs reported to them, and the nurse would report to the physician. Attempted interview with Resident #15's physician on 9/5/2025 at 3:15pm, phone number was left with the physician's office. Phone call was not returned. Record review of the facility's policy on Medication Orders revealed in part, Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. The policy did not cover following physician orders. Requested policy on Following Physician Orders on 9/5/2025 at 2:03pm by email from the Administrator and DON, the policy titled Medication Orders was sent.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for two (Nurse medication Cart used for hall A and Nurse medication Cart for secured unit) three medication carts reviewed for storage of medications. -The Nurse Cart (unsecured unit) and the Nurse cart (secured unit) had multiple medications open, some had no names and were not dated. This failure could place all residents at risk of not receiving the therapeutic benefit of medications, adverse reactions to medications and drug diversionObservation of the Nurse Cart for hall A on 09/04/2025 at 1:27 PM revealed the following medications open, with no names and not dated: 1. Mupirocin Ointment USP 2% opened and not dated2. Medi Honey 0.5 fl oz/1.5ml/18 with no resident name, opened and not dated3. Muscle rub net weight 3 oz with no resident name, opened and not dated4. Nystatin cream USP 100,000 um and 30 grams opened and not dated5. Relief Preparation soothing relief 0.9 oz no resident name, opened and not dated6. Mupirocin Ointment 2% net weight 22 gram opened and not dated7. Voltaren Arthritis pain net weight 100 gram no resident name, opened and not dated8. Santyl ointment 250 UM Hg opened and not dated In an interview on 09/04/25 at 1:27PM the ADON said the medications were supposed to have an open date when medications were opened because she didn't want to keep it forever. Observation of the Nurse Cart in the secured unit on 09/04/2025 at 1:48 PM revealed the following medications were open, with no names and not dated:Ketoconazole cream 2% opened and not datedKetoconazole Shampoo 2% opened and not dated In an interview on 09//204025 at 1:48 PM, LVN M stated she always checked the medication cart whenever she worked. She would always place an open date on medications that were opened for therapeutic effectiveness. LVN M stated she would notify the ADON of the medications opened and not dated. During an interview on 9/4/25 at 2:30 PM with the with DON, Regional Nurse and the Administrator, regarding medication storage, when asked about medications not dated when opened for administration the Regional Nurse said the nurses were not supposed to date the ointments. The nurse surveyor asked the Regional Nurse why most of the ointments and gels on nurse's medication carts had open date on it. Record review of the facility policy on Medication Storage PCU027 revised 2025 reflected in part: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Expired Medications and Medications with Shortened Expiration Dates Policy:Ensure that all medications in the facility are rotated and / or reviewed on a consistent basis to prevent having expired medications in the facility.Procedure:3. All medications will be labeled per State Board of Pharmacy Rules and Regulations that includes specific directions pertaining to expired or discarded after language.4. In the event that a medication has a shortened expiration date once opened the medication (open-dated) will be labeled with the date opened and the initials of the nurse. In the event the nurse is unsure if medication has a shortened expiration date that nurse will contact the Pharmacy to clarify or refer to the manufacturer recommendations. All OTC medication may be used until manufacturer's expiration date is reached or per the individual State Board of Pharmacy and State Health Departments rules and regulations.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents have a right to a dignified existence and treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #15) of 4 residents reviewed for dignity. -Resident #15 was observed eating in the dining room while soiled and staff present did not notice before serving Resident #15 her breakfast. This deficient practice could lead to psychosocial harm due to feelings of low self-esteem and/or embarrassment regardless of resident cognition. Record review of Resident #15's face sheet last captured 09/05/2025, she was a [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses included: metabolic encephalopathy (a brain dysfunction caused by an underlying condition, and could affect mood, thinking, memory or loss of consciousness), Major Depressive Disorder (prolonged sadness which can cause a loss of interest and withdrawal from familiar activities), dementia (loss of cognitive functioning like thinking, reasoning and memory and potential loss of emotional control and personality) and hypotension (low blood pressure. Record review of Resident #15's Quarterly MDS dated [DATE], she had a BIMS score of 00, indicating severe cognitive impairment. Resident #15 required moderate assistance with ADLs like toileting, eating and personal and oral hygiene and was coded as always incontinent of urine and bowel. Record review of Resident #15's care plan last captured 09/05/2025, she was care-planned for impaired cognitive function/dementia or impaired thought processes, with interventions keeping the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion. Resident #15 was also care-planned for ADL self-care performance deficit, with interventions including requiring assistance to use the toilet. Observation and attempted interview on 9/3/2025 at 7:52am with Resident #15, revealed she was lying in bed soiled in urine, and appeared in a pleasant mood. Resident #15 was unable to answer questions. Resident #15 got out of bed and walked without assistance to the dining area in the secured unit for breakfast soiled with urine. LVN E asked Resident #15 to sit down. Resident #15 sat by herself at a table. LVN E brought Resident #15 and set it in front of the resident who began eating her breakfast. Interview with CNA D on 9/8/2025 at 8:00am, she said that she did not see Resident #15 walking soiled from Resident #15's room to the dining room because CNA D was providing showers to another resident. CNA D said if she knew Resident #15 was wet, she would have changed Resident #15 first before bringing her to the dining room for breakfast. Interview with LVN E on 9/8/2025 at 3:20pm, she said she gave Resident #15 her breakfast tray but did not notice Resident #15 was wet and took Resident #15 to her room for incontinent care after surveyor intervention. LVN E came back after completing incontinent care and said that if residents were not changed in a timely manner, they could have skin breakdown. Nurses were responsible for ensuring that CNAs changed residents in a timely manner. Interview with the Administrator and DON on 9/4/2025 at 2:40pm, the DON said that it would be uncomfortable for Resident #15 to eat while soiled and it would affect her dignity. Staff should have redirected Resident #15 to her room and changed the resident. Record review of the facility's policy on perineal care dated 04/27/2022 revealed in part, It is essential that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations. Record review of the facility's policy on resident rights, undated, revealed in part, the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . The facility must provide equal access to quality of care .The resident has a right to be treated with respect and dignity, including .3. The right to reside and receive services in the facility with reasonable accommodation of resident (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs and preferences except when to do so would endanger the health or safety of the resident or other residents.		

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 (Dumpster A) of 1 facility dumpsters observed for proper garbage disposal. -Dumpster A's side door was open with trash inside on 9/2/2025. This failure could place residents at risk of contact with pests and associated diseases. Observation on 9/2/2025 at 6:34pm, revealed the left lid on Dumpster A was open. Interview with the Dietary Manager on 9/2/2025 at 6:35pm, she said the dumpster's lids should be closed at all times. The lids being left open could cause cross contamination, trash could be blown out by the wind and could get in the yard and smell. Animals could also get in the dumpster and could injure staff. The Dietary Manager said that she verbally educated housekeeping and nursing staff to close it, and she would do a formal in-service. Interview with the Administrator and DON on 9/3/2025 at 2:37pm, the Administrator said all staff were responsible for ensuring the dumpsters were closed. The DON said that if the dumpsters were open, it could cause cross-contamination, critters could come and that could affect residents' dignity. A policy on dumpsters was requested from the Dietary Manager on 9/3/2025 at 9:42am. On 9/3/2025 at 10:33pm. The Dietary Manager verbally confirmed the facility did not have a policy on dumpsters.		