STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455606	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Care Center	3301 View St Fort Worth, TX 76103

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit a resident to return to the facility after being hospitalized or placed on therapeutic leave for 1 of 3 residents (Resident #1) reviewed for bed hold. The facility failed to re-admit Resident #1 after he was hospitalized for having shortness of breath. Emergency services attempted to return Resident #1 on 12/18/25 and again on 12/19/25, and the facility sent him back to the hospital. This failure could place residents at risk of not getting the care and services required. Findings included:Record review of Resident #1's nursing home discharge MDS, dated [DATE], reflected Resident #1 was a [AGE] year-old male who was admitted to the facility originally on 08/18/21, readmitted [DATE] and again on 12/09/25. Resident #1's diagnoses included diabetes mellitus (high blood sugar levels), chronic respiratory failure with hypoxia (not having enough oxygen in the blood), chronic obstructive pulmonary disease (group of lung diseases that obstruct airflow and make breathing difficult), major depressive disorder (pervasive low mood, low self-esteem, and loss of interest or pleasure), end stage renal disease (kidney failure), morbid obesity (body mass index of 40 or higher), other seizures (sudden burst of electrical activity in the brain). The MDS reflected Resident #1 was dependent on staff with all activities of daily living skills. Also, the MDS Discharge Assessment did not indicate if a return was anticipated or not anticipated. Record review of Resident #1's current care plan reflected Resident #1 was Resistant to Care and at risk for injury, a decline in functional abilities, and not having their needs met in a timely manner. Resistance is related to: Resident refused dialysis care, refused medications/care, Resident refused/delays diabetic care, Resident frequently refuses incontinent care/wear brief, refused to wear clothes. Goal: Resident will maintain highest level of independence and not experience a decline in functional abilities. Resistance behaviors will not interfere with ADLs being met in a timely manner on a daily basis. Interventions included Use the Buddy System when interacting with Resident #1. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. Give a clear explanation of daily care activities prior to and as they occur during each contact. Encourage as much participation and interaction by the resident as possible. Provide resident with opportunities to make decisions during ADL cares and daily routine. If possible, negotiate a time for ADLs so that the resident participates in the decision making process and return at a time when resident is more likely to be compliant with receiving assistance with ADLs. Discuss the possible outcomes of not complying with therapeutic regimen.Record review of Resident #1's undated care plan reflected Resident #1 had Congestive Heart Failure. Goal: Resident will be free from complications related to Congested Heart Failure. Interventions included Give cardiac medications as ordered. Monitor/document/report to Physician PRN any signs and symptoms of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema (accumulation of fluid to lower extremities), shortness of breath on exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation (to listen to the sounds of the lungs with stethoscope) of the lungs, Orthopnea (shortness of breath when lying down), weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. Oxygen therapy per physicians orders. Vital signs as needed.Record review of Resident #1's undated care plan reflected Resident #1 had a diagnosis of diabetes and is at risk for unstable blood sugars and abnormal lab results. Goal: Resident will be free from the signs and symptoms of hyper/hypoglycemia (high/low blood sugar). Interventions included Administer diabetic medications as ordered by the physician. Monitor for adverse reactions and report abnormal as detected. Provide therapeutic diet as ordered. Monitor blood Sugar as ordered by physician. Administer sliding scale insulin if ordered. For any blood sugars not within the acceptable parameters as dictated by the physician, document and notify the physician. Monitor for signs and symptoms of hyperglycemia such as: Reduced appetite, increased thirst, urinary frequency, weight loss, fatigue, nausea, vomiting, dry skin, muscle cramps, Kussmaul breathing (deep, labored breathing pattern), acetone breath (smells fruity), stupor (mental condition marked by absence of spontaneous movement), and coma. Document and report to the physician as needed.Record review of Resident #1's undated care plan reflected Resident #1 had dialysis. Resident #1 received dialysis related to renal failure and is at risk of the potential complications of dialysis related to End Stage Renal Disease. Goal: Resident will have no complications from routine dialysis. Interventions included Encourage resident to attend scheduled dialysis appointments. Hemodialysis treatments are to be performed

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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** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 resident of 8 residents (Resident #2) reviewed for care plans.The facility failed to address Resident #2's wound, and her non-compliance with care in her care plan.This failure could place residents at risk of not receiving the care they require. Findings included:Record review of Resident #2's quarterly MDS, dated [DATE], revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included a stroke that affected her left side, poor circulation, and nicotine dependence. Her BIMS score was 11, indicating she was moderately cognitively impaired. Her Functional Abilities assessment revealed she was totally dependent on staff for her ADLs. She had no pressure ulcers according to her Skin Conditions assessment. Record review of Resident #2's care plan, dated 10/06/25, revealed she had cognitive impairment, had an ADL self-care deficit, she was at risk of developing pressure ulcers, and she had fragile skin. It did not address the resident's Arterial wound (wound to leg caused by poor blood flow) or her non-compliance with care. Record review of Resident #2's Skin Issue assessment, dated 10/28/25, revealed she had developed an Arterial wound to her left outer ankle. Her assessment on 12/12/25 revealed the wound was larger and had poor healing. Record review of Resident #2's wound physician's note on 12/10/25 revealed the resident had poor healing related to her smoking and failure to offload pressure to the wound. His measurements revealed the wound was larger than it was initially. In an interview on 12/22/25 at 1:46 PM CNA-A stated Resident #2 did not like getting out of bed. Her. hHer family would get her up when they came to visit, but otherwise the resident stayed in bed. Staff would try to position the resident on her right side to take pressure off her wound, but the resident would eventually make it back to her backside and tuck her left foot under her right leg. She stated staff tried using pillows to keep the left foot clear of the right leg, but the resident would work the pillow out. In an interview on 12/22/25 at 2:30 PM LVN-B stated Resident #2 rarely got out of bed. Her family would take her out to smoke and sit in the common area to visit when they were there, otherwise the resident wanted to stay in bed. LVN-B stated the staff tried multiple things to keep pressure off the resident's wound, but she would eventually get her foot under her other leg. She stated the resident was educated multiple times about offloading pressure. In an interview on 12/22/25 at 4:55 PM the Wound Care Nurse stated the resident was seen weekly by the wound care physician, had daily dressing changes, and her wound continued to deteriorate. The resident was educated about offloading pressure, and she would say That's what you say (meaning she did not believe what she was being told) and continue to be non-compliant. In an interview on 12/22/25 at 4:35 PM the ADON stated she was responsible for keeping care plans updated on the South Hall residents. She stated she was new to the position and facility and was trying to catch up. She stated the admitting nurse created the baseline care plan, the MDS nurses added more detail to it after their assessment, and then the ADONs kept the care plan updated with changes. Review of the facility's policy Comprehensive Care Plans, dated 02/10/21, reflected: 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 maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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** Based on observations, interviews, and record review, the facility failed to ensure full visual privacy for each resident in 6 rooms of 30 rooms (Rooms # 12, # 15, #23, # 71, #72 and #77) reviewed for privacy. The facility failed to maintain functional window blinds to provide privacy for the residents of Rooms #12, # 15, #23, # 71, #72 and #77. This failure could place residents at risk for exposure and decreased sense of dignity. Findings included:Observation on 12/22/25 at 9:45 AM in room [ROOM NUMBER] revealed the window blinds had 8 slats that were broken, allowing visualization of the bed from outside the facility. Observation on 12/22/25 at 9:53 AM in room [ROOM NUMBER] revealed the window blinds had 4 slats that were broken, allowing visualization of the bed from outside the facility.Observation and interview on 12/22/25 at 10:00 AM in Room # 77 revealed the window blinds had 12 slats that were broken, allowing visualization of the bed from outside the facility. The resident stated the blinds had been broken a long time, stating the needed to be replaced for privacy. Observation on 12/22/25 at 10:25 AM in room [ROOM NUMBER] revealed the window blinds had 10 broken slats, allowing visualization of the bed from outside the facility. Observation and interview on 12/22/25 at 10:30 AM in room [ROOM NUMBER] revealed the window blinds had 7 broken slats, allowing visualization of the bed from outside the facility. The resident did not like the broken blinds, stating it let people see in. Observation on 12/22/25 at 11:00 AM in room [ROOM NUMBER] revealed the window blinds had 12 broken slats, allowing visualization of the bed from outside the facility. In an interview on 12/22/25 at 11:54 AM, MA-C stated any repairs needed to the resident rooms were entered into the Maintenance Logbook, located at each nurses' station, for maintenance to address. She was unaware of any blinds in need of replacement. In an interview on 12/22/25 at 11:58 AM, LVN-D stated anything that needed to be fixed in the resident rooms was written in the Maintenance Logbook or told directly to the Maintenance Director. She was unaware of any blinds that needed to be replaced. Record review on 12/22/25 at 12:00 PM of Maintenance Logbooks for all three stations, revealed no requests for blind repair/replacement. In an interview on 12/22/25 at 5:00 PM, the Maintenance Director stated he was responsible for making repairs to the physical plant. He stated staff had been educated on the process of entering any repair requests in the logbook. He stated he checks the books the first thing in the morning, and then several times throughout the day. He stated he tries to make a sweep of all the rooms once a month, looking for things that need to be addressed, but he relies heavily on the staff to alert him about repairs needed. He was unaware there were blinds that needed replacement, he stated he has replacements in stock and would get them replaced. Record review of the facility's policy Homelike Environment, dated 04/24/25, reflected: .A homelike environment is essential for promoting the comfort, dignity, and quality of life of residents. 2. Privacy and Dignity: Ensure that residents have privacy and that their dignity is maintained at all times. This includes respecting their personal space and providing private areas for personal care and family visits.