Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675622	A. Building B. Wing	08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5801 Bryant Irvin Rd Fort Worth, TX 76132	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 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 provide residents and responsible parties the right to participate in the development and implementation of their person-centered plan of care for 1 of 9 residents (Resident #14) reviewed for quarterly care plans.The facility failed to provide Resident #14 and responsible parties with 4 quarterly care plan conference meetings for the last 12 months. Resident #14's last care plan meeting was dated 08/02/24.This failure could place residents at risk of not receiving inadequate interventions individualized to their care needs.Findings included:Record review of Resident #14's quarterly MDS assessment, dated 05/10/25, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. The assessment reflected the resident's cognition was not documented. The resident had diagnoses which included stroke (medical emergency where blood flow to the brain is interrupted, leading to brain cell death from lack of oxygen and nutrients). Record review of Resident #14's care plan, 05/12/25 reflected Problem: [Resident #14] has impaired cognitive function/dementia or impaired thought processes r/t Dementia, difficulty making decisions, impaired decision making, long term memory loss/short term memory loss. Goal: [Resident #14] will maintain current level of cognitive function through the review date. Interventions: Communicate with [Resident #14]/family/caregivers regarding his capabilities and needs. Record review of Resident #14's progress notes reflected the last documentation from the Social Worker pertaining to a care conference was on 08/02/24, and the entry was: Telephone care conference was held with SWA, ADON and spouse of [Resident #14] . Observation and attempted interview on 08/19/25 at 11:28 AM, revealed Resident #14 in bed and awake. Resident #14 was not able to answer questions due to his condition. The resident did not appear to be in distress or discomfort.Interview on 08/19/25 at 2:54 PM with Resident #14's POA revealed, she was very involved in the Resident #14's care. She stated the facility staff were good about notifying her if the resident had a change in condition; however, she had not had a care plan meeting in a very long time. Resident #14's POA stated she could not recall when the last time a care plan was completed. She stated she had good communication with the facility, but she would like to have a care plan meeting to address any concerns. Interview and record review on 08/21/25 at 11:17 AM, with the Social Worker revealed she was the Social Worker assigned to Resident #14. She stated Resident #14's care plan meetings were usually held over the phone due to Resident #14's POA working. She stated the last care plan meeting was held either in June or July 2025, and she and the POA were the ones who attended the care plan meeting. She stated the previous care plan meeting was held in April 2025, but the exact date was not known. The Social Worker stated she had a close relationship with Resident #14's POA. The Social Worker reviewed Resident #14's clinical record, and she indicated on 07/10/25 there was not a care plan meeting but an update regarding Resident #14's dental care. She stated she could not recall when the last care plan meeting was, but she knew there was no care plan meeting in May 2025. She stated she did not know why a care plan meeting was not held, and she stated it had been overlooked. She stated there was no potential risk to the resident because Resident #14's POA was involved. Interview on 08/21/25 at 4:25 PM, with the DON revealed the Social Worker was responsible for the care plan meetings. She stated she could not recall the last care plan meeting she had attended for Resident #14. The DON stated the Social Worker and the ADONs completed the care plan meetings. She stated if she was needed, she would attend. The DON stated care plan meetings should be completed quarterly and as needed with family. She stated care plan meetings were needed to keep the family informed of the care being provided to the resident. Interview and record review on 08/21/25 at 4:45 PM, with ADON B revealed the Social Worker was responsible for scheduling the care plan meeting. ADON B stated she would attend the meetings. She stated she took over the ADON position in February 2025 and had not attended a care plan meeting for Resident #14. She stated she did not know when the last time a care plan meeting was held for Resident #14. ADON B reviewed Resident #14's Social Worker notes and stated the last documented care plan conference was August 2024. ADON B stated there was no potential risk because family was involved; however, care plan meetings were needed to address a resident's current condition and for family to be able to voice any concerns. Record review of the facility's Comprehensive Care Plan policy, dated 10/24/22 reflected the following: The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: .e. The resident and the resident's representative, to the extent practicable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER: Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5801 Bryant Irvin Rd Fort Worth, TX 76132	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 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 observations, interviews, and record reviews, 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 for 1 resident of 9 residents (Resident #74) reviewed for care plans. The facility failed to develop a care plan addressing Resident #74's preference to provide self-care for his colostomy (an opening in the colon that lets stool pass from the body without going through the anus).The failure placed residents at risk of not having their care preferences care planned which could result in decreased quality of life. Findings included:Record review of Resident #74's quarterly MDS assessment, dated 07/18/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including colostomy status (an opening (stoma) in the colon (large intestine) to divert stool outside the body), vascular parkinsonism (blood vessel problems in the brain, such as small strokes, that damage the areas controlling movement), hypertension (high blood pressure), polyneuropathy (damage or disease affecting peripheral nerves), Non-Alzheimer's Dementia. Resident #74 had a BIMS score of 08, indicating severe cognitive impairment. Resident #74 required supervision or touching assistance with toileting hygiene meaning (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.)Record review of Resident #74's care plan, revised 07/07/25, reflected: Problem: The resident has an alteration in gastrointestinal status r/t colostomy status d/t rectal resection r/t colon cancer. 7/3/25 Rash around stoma-Physician notified Goal: The resident will remain free from discomfort, complications or s/sx related to gastrointestinal alterations with colostomy status through review date. Interventions: Change colostomy bag as needed. Cut wafer to fit around stoma as needed. Colostomy care q shift & PRN burp bag as needed. Interview on 08/19/25 at 3:44 PM, with Resident #74 revealed he had an ostomy bag. Resident #74 stated he completed his own ostomy care because he did not like anyone helping him. Resident #74 stated he had been doing his own ostomy care for more than 20 years and liked it a certain way. Resident #74 stated he had some irritation around the stoma, but it had cleared. Resident #74 stated the staff were aware. Interview on 08/21/25 at 11:52 AM, with ADON B revealed Resident #74 liked doing his own ostomy care. She stated nurses either assisted or observed the resident do it. ADON B stated Resident #74 refused to let anyone assist him. She stated since it was Resident #74 preference was to complete his own ostomy care it should be care planned. ADON B stated the MDS Coordinator were responsible for care plans. ADON B reviewed Resident #74's care plan, and she revealed the resident's ostomy care preference was not care plan. Interview on 08/21/25 at 1:09 PM, with the MDS Coordinator revealed she had been employed for four months at the facility. She stated she was responsible for updating care plans for long term care residents. She stated she was not aware Resident #74 completed his own ostomy care. She stated it should had been care plan. She stated she was notified today (08/21/25) by ADON B of Resident #74's preference. She stated it should be care plan because all staff should know the resident plan of care and preference. Interview on 08/21/25 at 1:45 PM, with LVN D revealed she was the nurse for assigned to Resident #74. She stated Resident #74 refuses to let anyone assist him with his ostomy care. She stated Resident #74 prefers to do his own ostomy care. She stated it should be care plan because Resident #74 refuses the help and does not like anyone helping him. LVN D stated she was not sure who was responsible for care plans. Interview on 08/21/25 at 4:29 PM, with the DON revealed Resident #74 preferred to do his own ostomy care. The DON stated she was informed today (08/21/25) that it was not care plan and it should be. She stated the care plans should address the resident preference on providing his own care. Record review of the facility's Comprehensive Care Plan policy dated 10/24/22 reflected the following: 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 psychosocial needs that are identified in the resident's comprehensive assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 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 ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 9 residents (Resident #14) for care plan revisions. The facility failed to review and revise Resident #14's comprehensive care plan after the MDS assessment was completed on 05/10/25. Resident #14's last care plan meeting was dated 08/02/24.This failure placed residents at risk of not having their individual needs met. Findings included:Record review of Resident #14's quarterly MDS assessment, dated 05/10/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmission on [DATE]. The assessment reflected the resident cognition was not documented. The resident had diagnoses which included stroke (medical emergency where blood flow to the brain is interrupted, leading to brain cell death from lack of oxygen and nutrients). Record review of Resident #14's care plan, 5/12/25 reflected Problem: [Resident #14] has impaired cognitive function/dementia or impaired thought processes r/t Dementia, difficulty making decisions, impaired decision making, long term memory loss/short term memory loss. Goal: [Resident #14] will maintain current level of cognitive function through the review date. Interventions: Communicate with [NAME]/family/caregivers regarding his capabilities and needs.Record review of Resident #14's progress notes revealed the last documentation from Social Worker pertaining care conference was on 08/02/24. Telephone care conference was held with SWA, ADON and spouse of [Resident #14] . Observation and attempted interview on 08/19/25 at 11:28 AM revealed Resident #14 in bed and awake. Resident #14 was not able to answer questions due to his condition. The resident did not appear to be in distress or discomfort. Interview on 08/19/25 at 2:54 PM, the Resident #14's POA revealed she was very involved in the resident's care. She stated the facility staff were good about notifying her of any change in the resident's condition; however, she had not had a care plan meeting in a very long time. Resident #14's POA stated she could not recall when the last time was a care plan was completed. She stated she had a good communication with the facility, but she would like to have a care plan meeting to address any concerns. Interview on 08/21/25 at 11:17 AM, the Social Worker revealed she was the Social Worker assigned to Resident #14. She stated Resident #14's care plan meetings were usually held over the phone due to Resident #14's POA working. She stated the last care plan meeting was held either June or July 2025 and it was only herself and the POA who attended the meeting. She stated the previous care plan meeting was held in April 2025, unknown of the exact date. The Social Worker stated she had a close relationship with Resident #14's POA. Record review of Resident #14's clinical records, Social Worker indicated on 07/10/25 was not a care plan meeting but an update regarding Resident #14's dental care. Social Worker stated she could not recall when the last care plan meeting was, she stated there was no care plan meeting for May 2025. She stated she does not know why a care plan meeting was not held, she stated it was overlooked. She stated there was no potential risk to the resident because Resident #14's POA was involved. Interview on 08/21/25 at 4:25 PM, the DON revealed the Social Worker was responsible for care plan meeting. She stated she could not recall the last care plan meeting she had attended for Resident #14. The DON stated the Social Worker and the ADONs complete the care plan meetings and if she was needed, she would attend. The DON stated care plan meetings should be completed quarterly and as needed with family. She stated care plan meetings were needed to keep family informed of the care being provided to the resident. Interview on 08/21/25 at 4:45 PM, the ADON B revealed the Social Worker was responsible for scheduling care plan meeting and ADON would attend. She stated she took over the ADON position in February 2025 and had not attended a care plan meeting for Resident #14. She stated she does not know when the last time a care plan meeting was held for Resident #14. ADON B reviewed Resident #14 Social Worker notes and stated the last documented care plan conference was August 2024. ADON B stated there was no potential risk because family was involved; however, care plan meetings were needed to address resident current condition and for family to be able to voice any concerns. Record review of facility Comprehensive Care Plan policy, dated 10/24/22 reflected the following: The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: .e. The resident and the resident's representative, to the extent practicable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. (continued on next page)

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

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675622	A. Building B. Wing	08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 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 observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health by providing foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 1 of 18 residents (Resident #74) reviewed for foot care.The facility failed to ensure Resident #74's toenails were clipped. This failure could result in residents developing fungal infections or other podiatric problems. Findings included:Record review of Resident #74's quarterly MDS assessment, dated 07/18/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including colostomy status (an opening (stoma) in the colon (large intestine) to divert stool outside the body), vascular parkinsonism (blood vessel problems in the brain, such as small strokes, that damage the areas controlling movement), hypertension (high blood pressure), polyneuropathy (damage or disease affecting peripheral nerves), Non-Alzheimer's Dementia. Resident #74 had a BIMS score of 08, indicating severe cognitive impairment. Resident #74 required partial/moderate assistance with his personal hygiene. Record review of Resident #74's care plan, revised 03/24/25, reflected: Problem: The resident has Peripheral Vascular Disease (PVD) DX. Goal: The resident will be free of s/sx of PVD through the review date. Interventions: Educate the resident on the importance of proper foot care including: proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks.Record review of the facility's podiatry visits for March 2025 through August 2025 reflected Resident #74 had not been seen by the Podiatrist. Observation and interview on 08/20/25 at 9:05 AM, revealed Resident #74 was in his wheelchair watching television. Resident #74 stated he was waiting on staff to come assist with putting his socks on. Observation of Resident #74's feet revealed the third and fourth toenails on his left foot and right foot were long and curving in. Resident #74 stated he had been asking staff to see a Podiatrist. He stated he could not recall the name of the staff; however, every time he asks the staff, the staff told him the Podiatrist had already come to the facility, and he had to wait for the next visit. Resident #74 stated he had been asking to see a Podiatrist since May 2025. He stated if he was able to bend over, he would cut them himself, but he cannot. Resident #74 stated he was not a diabetic resident. Interview on 08/21/25 at 1:24 PM, CNA C revealed she was the CNA assigned to Resident #74. She stated if a resident was diabetic fingernails were cut by the nurses and toenails were cut by the Podiatrist. She stated if the resident was not diabetic then the CNAs were able to file down fingernails and the nurses would cut toenails. CNA C stated she had observed Resident #74 toenails and noticed the toenails were curving in. She stated she notified the nurse, unknown of the nurse's name. She stated Resident #74 had not complained of pain. Interview on 08/21/25 at 1:33 PM, LVN D revealed the nurses were responsible for cutting nails unless the resident was diabetic. She stated podiatry comes to the facility but was not sure how often. LVN D stated she was not sure if Resident #74 had been seen by the Podiatrist. She stated Resident #74 had not complained about his toenails. Observation and follow-up interview on 08/21/25 at 2:01 PM, revealed Resident #74's right foot fourth toenail was long and curved in and left foot third and fourth toenails were long and curving in. LVN D stated Resident #74's toenails were overgrown and needed to be cut. Resident #74 denied any pain but would like them to be cut. LVN D stated the potential risk of not cutting the resident's toenails was that it could lead to the toenail cutting into the skin.Interview on 08/21/25 at 2:05 PM, ADON B revealed Resident #74 toenails needed to be cut by the Podiatrist. She stated she had asked the Social Worker for a podiatry referral on 05/15/25, but Resident #74 had not been seen by the Podiatrist. She stated she had not followed-up on this. ADON B stated Resident #74 had not requested to see the Podiatrist. She stated the potential risk of not cutting residents toenails would be residents not being able to wear shoes. Interview on 08/21/25 at 2:19 PM, the Social Worker revealed she was responsible for sending referrals. She stated she had just received a podiatry referral today (08/21/25) for Resident #74. She stated she was not aware Resident #74 needed to be seen by the Podiatrist. She stated normally she would get the order and then she put in the referral. She stated prior to today (08/21/25) she had not received a podiatry referral for Resident #74. Interview on 08/21/25 at 4:31 PM, the DON revealed she was made aware today (08/21/25) of Resident #74's toenails. She stated she was not aware Resident #74 had requested to see the Podiatrist. She stated the Social Worker was responsible for completing referrals to podiatry. She stated if a resident voiced a concern regarding podiatry, it was the responsibility of the ADONs to follow-up on the referrals. She stated residents'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5801 Bryant Irvin Rd Fort Worth, TX 76132	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who needs respiratory care, is provided with such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 of 2 residents (Residents #19 and #37) reviewed for non-invasive ventilation care.1. The facility failed to ensure there were physician orders for the use of Resident #19's BiPAP machine, which is a non-invasive ventilation machine that is capable of generating two adjustable pressure levels.2 The facility failed to ensure there were physician orders for the use of Resident #37's CPAP machine, which is a non-invasive ventilation machine that involves the administration of air usually through the nose by an external device at a predetermined level of pressure. These failures placed residents at risk of not receiving adequate and necessary respiratory care.Record review of Resident #19's admission MDS, dated [DATE], reflected the was resident was admitted to the facility on [DATE]. The resident's diagnoses included obstructive sleep apnea, quadriplegia, and morbid obesity. Resident #19 had a BIMS score of 15, indicating he was cognitively intact. Resident #19 also required substantial assistance with his ADLs. His Special Treatments did not indicate the use of a Bi-PAP machine. Record review of Resident #19's care plan, dated 07/21/25, revealed he had altered respiratory status related to sleep apnea with interventions that included the use of a Bi-PAP machine on home settings and elevating head of bed as tolerated. Record review of Resident #19's physician orders revealed there was not an order for use of the Bi-PAP or what settings to use.Following surveyor inquiry, the DON added Bi-PAP orders and a respiratory consult on 08/20/25 for Resident #19.Observation and interview on 08/19/25 at 9:48 AM, revealed Resident #19 had a Bi-PAP machine with a face mask on his bedside table. Resident #19 stated the Bi-PAP machine was his from home, and he had been using it since he was admitted to the facility. He stated staff helped him clean his mask about once a week. He stated he had not met with a respiratory therapist that he knew of, but he was comfortable using the machine. Record review of Resident #37's admission MDS, dated [DATE], reflected the resident was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure, emphysema, and morbid obesity. Resident #37 had a BIMS score of 15, indicating she was cognitively intact. Resident #37 required substantial assistance with her ADLs. Her Special Treatments did not indicate the usage of CPAP. Record review of Resident #37's care plan dated 06/09/25 reflected she was on oxygen therapy, and she had a history of shortness of breath related to her emphysema and her heart failure with interventions of a nasal canula at 4 lpm. She had not been care planned for CPAP. Record review of Resident #37's physician orders revealed no order for use of the CPAP machine nor what settings to use. Following surveyor inquiry, the DON added CPAP orders and a respiratory therapy consult on 8/20/25 for Resident #37.Observation on 08/19/25 at 12:46 PM, revealed Resident #37 had a CPAP machine at her bedside.Interview on 08/19/25 at 1:30 PM, Resident #37 revealed the CPAP machine was not hers. She stated someone had brought it to her after she was admitted to the facility. She stated she used one at home and was familiar with how to use it. Resident #37 stated she had not met with a respiratory therapist that she knew of. Interview on 08/20/2025 at 12:45 PM, LVN A revealed the nurses were responsible for cleaning the resident's mask once a week. He stated this care was usually done during the night shift. He stated there should be an order for the settings from the physician, and it should also be in her care plan. LVN A stated he was not aware there was no physician order for CPAP. Interview on 08/20/25 at 12:49 PM, the DON revealed there should be a physician order for the CPAP, and it should be added to her care plan. She stated the night shift nurses cleaned the mask once a week and assisted the resident with putting it on. They should also check that there was a good seal. She was not aware there was no order for the resident's CPAP. The DON stated there was a Respiratory Therapist that would come to the facility when they were ordered to consult and then follow the resident while they were in the facility. The DON state she did not know if the therapist had seen Resident #37. Record review of the facility's policy Noninvasive Ventilation dated 03/12/25 reflected:.2. The facility will obtain an order for the use of a CPAP, BiPAP, or AVAPS device and settings from the practitioner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER: Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5801 Bryant Irvin Rd Fort Worth, TX 76132	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 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 observation, interview, and record review 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 1 of 5 residents (Resident #14) reviewed for pharmacy procedures.1. ADON B failed to follow the facility policy of flushing Resident #14's gastrostomy tube with 5-10 mL (or prescribed amount) of water between medications, when she administered medication through gastronomy tube (feeding tube). 2. ADON B failed to check for residual through aspiration before administering medication to Resident #14. These failures could place residents at risk of physical and chemical incompatibilities leading to an altered therapeutic response and put residents who received medications via gastrostomy tube at risk for gastronomy tube blockage and medication interaction. Findings included:1. Record review of Resident #14's quarterly MDS assessment, dated 05/10/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. The assessment reflected the resident cognition was not documented. The resident had diagnoses which included stroke (a condition where blood flow to the brain is interrupted, leading to brain cell death from lack of oxygen and nutrients). The nutritional approaches revealed the resident received nutrition via a feeding tube. Review of Resident #14's August 2025 Physician Orders reflected there were no orders for flushing the resident's gastrostomy tube between medication administration. The orders reflected: Enteral Feed Order as needed Prior to use check placement of g-tube by observing change in external length or marking on the tube at the exit site to determine if tube has migrated AND observe for increase of volume of aspirate of gastric contents. Notify physician of change.Observation on 08/20/2025 at 8:49 AM, revealed ADON B prepared medications outside Resident #14's room. She prepared the following medications: Polyethylene glycol 3350 Powder for Oral Solution [MiraLAX] 17g mix with 6-8 OZ water via g-tube. apixaban 5 mg Oral Tablet [Eliquis]1 tablet via g-tube methocarbamol 500 mg 1 tablet daily via g-tube lactulose 30mls via g-tube daily via g-tube magnesium oxide 400 mg 1 tablet daily via g-tube meloxicam 7.5 mg 1 tablet via g-tube daily tizanidine 2 mg 1 tablet daily tramadol hydrochloride 50 mg 1 tablet daily via g-tube. levetiracetam 5 ML 100 mg/ml bid via g-tube. loratadine 10mgs 1 tablet daily via g-tube. metoclopramide 5 mg 1 tablet a day via g-tube and senna syrup 5 ml twice daily via g-tube ADON B crushed the medications and put them in separate cups and mixed with 5 ml of water. She then washed her hands, put on gloves and gown, and went to Resident #14's room. ADON B positioned Resident #14 in an upright position. She flushed the gastrostomy tube with 30 ml of water, and she proceeded to administer the medications one at a time. ADON B did not flush the gastrostomy tube with water between each medication. ADON B flushed the gastrostomy tube with 30 ml of water after she finished administering the medications. Interview with ADON B on 08/20/2025 9:28 AM, revealed she was aware of the order to flush the gastrostomy tube with 5-10 ml of water between medication administration through gastrostomy tube for Resident #14. She said she forgot to flush the gastrostomy tube between each medication administration. ADON B stated failure to flush in between the medications could lead to gastrostomy tube blockage and medication interactions. She also stated she was supposed to check for residual before administering medication through gastronomy tube. She stated failure to check for residual before administering medication could lead to aspiration. She stated she had received training on medication administration via gastrostomy tube, and she had also done skills check on g-tube. Interview with the DON on 08/21/2025 4:45 PM, revealed her expectation was for the nurses to crush medications for gastronomy tubes in different cups, mix with water, and flush the tube before, between, and after medication administration. She stated she was responsible for monitoring the nurses. She stated the risk of not flushing before between and after medication administration would be medication interactions. She also stated her expectation was all staff should verify placement visually and then they should aspirate to verify placement and residual before they administer medication. She stated if staff were not checking residual it could lead to aspiration and infection. Record review of the facility's current Medication Administration policy revised 10/01/2019, reflected the following: Flush with 5-I0ml warm water between each medication. Pinch tubing below the syringe tip when each volume of liquid clears the syringe to avoid excessive air from entering stomach. This can cause discomfort or emesis. I. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above I 00ml.