STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on record review and interview 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 eneds of each resident for 1 (Resident #1) of 5 residents reviewed for pharmaceutical services. The facility failed to transcribe Resident #1's order for Amitriptyline (an antidepressant medication) accurately. The dose was entered into the EHR as 100 mg per day rather than the ordered 25 mg per day. This failure could place residents at risk of receiving incorrect doses of medication resulting in overmedication. Findings Included: Record review of Resident #1's admission record dated 05/08/24 revealed a [AGE] year-old male admitted for a short term to the facility on [DATE] with diagnoses that included, but were not limited to, aftercare following joint replacement surgery, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), fracture of base of neck of right femur (break in the neck of the big bone of the right leg near where the ball goes into the hip socket), volume depletion (abnormally low extracellular fluid in the body due to decrease in salt and water or decrease in blood volume), hypo-osmolality (decrease in the levels of electrolytes, chemicals, and other fluids in the blood) and hyponatremia (sodium levels in the blood are extremely low can cause nausea, headache, fatigue, or confusion), type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), and heart failure (heart muscle fails to pump blood as it should). Resident #1 was discharged from the facility to a hospital on 05/04/24. Record review of Resident #1's MDS front sheet in the EHR revealed his Admission MDS was in progress. Record review of Resident #1's in progress Admission MDS revealed Section C had been completed and Resident #1 had a BIMS of 11 which indicated moderately impaired cognition. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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	Record review of Resident #1's baseline care plan completed by DON on 05/03/24 revealed he was able to communicate easily with staff. Resident #1's goals were to remain safe and get stronger to return to the community. Resident #1 needed one-person physical assist across his ADL's except for eating where he only needed set up assistance. Resident #1 was cognitively alert and intact. Resident #1 was receiving psychotropic medication. His medication list was provided to him and reconciled by him. Record Review of Resident #1's Order Summary Report dated 05/08/24 revealed an order for Amitriptyline Tablet 100 MG each day at bedtime for depression. Record review of Resident #1's Progress Notes revealed the following: A note dated 05/05/24 at 04:02 PM written by DON which read, Md was going through dc (discontinued) medication list and caught that amitriptylline [sic] was put in at 100 mg qhs instead of 25 mg. The note was labelled LATE ENTRY. A note dated 05/01/24 at 01:03 PM written by LVN for Amitriptyline Tablet 100 MG by mouth at bedtime for depression Severity: Moderate. Record review of Resident #1's Medication Administration Record dated 05/08/24 revealed he received 100 mg of Amitriptyline at bedtime on 05/01/24, 05/02/24, and 05/03/24. Record review of Resident #1's hospital records from his stay 04/27/24 to 05/01/24 revealed he was taking Amitriptyline 25 mg per day at home prior to his admission to the hospital. During an interview on 05/08/24 at 01:21 PM MD stated after he discovered Resident #1 had been taking four times the prescribed dose of Amitriptyline during his stay in the facility he spoke to the admitting nurse, LVN. MD stated LVN said he (LVN) made a mistake when he was entering the order into the EHR. During an interview on 05/08/24 at 02:03 PM DON stated the charge nurse on duty was responsible for entering orders into the EHR when a resident was admitted . She stated the next shift charge nurse was supposed to review the orders to ensure they were correct. She stated she had noticed that was not happening so recently she had a meeting with her nurses and told them after the second shift reviews the orders, they need to give her a report so she can review them a second time and ensure they are correct. She stated the charge nurse admitting Resident #1 was LVN. She stated a possible negative outcome of receiving four times the prescribed amount of Amitriptyline was adverse side effects; increased sedation. During an interview on 05/08/24 at 03:30 PM RRN was asked for a policy addressing accuracy of medical records. During an interview on 05/08/24 at 03:40 PM RRN stated the facility did not have a policy that addressed accuracy of medical records. Attempts were made on 05/08/24 at 02:11 and 02:14 as well as 05/09/24 at 09:45 AM and 09:46 AM to reach LVN for interview. All attempts were unsuccessful. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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	Record review of facility policy titled Admission Assessment and Follow Up: Role of the Nurse and dated September 2012 revealed the following: . 7. Conduct an admission assessment (history and physical), including: . d. Current medications and treatments. Reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures. Record review of facility policy titled Administering Medications and dated April 2019 revealed the following: . Medications are administered . as prescribed. 4. Medications are administered in accordance with prescriber orders, . Record review of facility policy titled Medication and Treatment Orders and dated July 2016 revealed the following: . Orders for medications and treatments will be consistent with principles of safe and effective order writing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to ensure residents were free from significant medication errors for 1 (Resident #1) of 5 residents reviewed for medication errors. The facility failed to follow physician's orders in that Resident #1 was given 100 mg of Amitriptyline (an antidepressant medication) rather than the 25 mg the physician ordered. This failure could place residents at risk for oversedation such as dizziness, drowsiness and fatigue. Findings Included: Record review of Resident #1's admission record dated 05/08/24 revealed a [AGE] year-old male admitted for a short term to the facility on [DATE] with diagnoses that included, but were not limited to, aftercare following joint replacement surgery, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), fracture of base of neck of right femur (break in the neck of the big bone of the right leg near where the ball goes into the hip socket), volume depletion (abnormally low extracellular fluid in the body due to decrease in salt and water or decrease in blood volume), hypo-osmolality (decrease in the levels of electrolytes, chemicals, and other fluids in the blood) and hyponatremia (sodium levels in the blood are extremely low can cause nausea, headache, fatigue, or confusion), type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), and heart failure (heart muscle fails to pump blood as it should). Resident #1 was discharged from the facility to a hospital on 05/04/24. Record review of Resident #1's MDS front sheet in the EHR revealed his Admission MDS was in progress. Record review of Resident #1's Admission MDS which was in progress revealed Section C had been completed and Resident #1 had a BIMS of 11 which indicated moderately impaired cognition. Record review of Resident #1's baseline care plan completed by DON on 05/03/24 revealed he was able to communicate easily with staff. Resident #1's goals were to remain safe and get stronger to return to the community. Resident #1 needed one-person physical assist across his ADL's except for eating where he only needed set up assistance. Resident #1 was cognitively alert and intact. Resident #1 was receiving psychotropic medication. His medication list was provided to him and reconciled by him. Record Review of Resident #1's Order Summary Report dated 05/08/24 revealed an order for Amitriptyline Tablet 100 MG each day at bedtime for depression. Record review of Resident #1's Progress Notes revealed the following: A note dated 05/05/24 at 04:02 PM written by DON which read, Md was going through dc (discontinued) medication list and caught that amitriptylline [sic] was put in at 100 mg qhs instead of 25 mg. The note was labelled LATE ENTRY. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note dated 05/01/24 at 01:03 PM written by LVN for Amitriptyline Tablet 100 MG by mouth at bedtime for depression Severity: Moderate. Record review of Resident #1's Medication Administration Record dated 05/08/24 revealed he received 100 mg of Amitriptyline at bedtime on 05/01/24, 05/02/24, and 05/03/24. Record review of Resident #1's discharge record revealed he was discharged due to being unresponsive on 05/04/24 at 12:16 PM. Record review of Resident #1's hospital records from his stay 04/27/24 to 05/01/24 revealed he was taking Amitriptyline 25 mg per day at home prior to his admission to the hospital. The records further revealed he had an elevation in his white blood cells which indicated an infection of some kind on the two days before he was released to the facility (04/30/24 and 05/01/24). Record review of Resident #1's hospital records from his stay 05/04/24 to 05/08/24 revealed he was admitted to the hospital with elevated white blood cell count, diagnosis of a UTI (urinary tract infection), and elevated his troponin levels (an indicator in blood that can indicate a cardiac event). During an interview on 05/07/24 at 03:00 PM Resident #1's FM A stated Resident #1 was living on his own and in his right mind prior to his hip surgery. She stated he was the treasurer for his local club. FM stated Resident #1 had a history of becoming dehydrated and she, FM B, and FM C could recognize the signs. She stated when she and FM C visited Resident #1 on 05/03/24 he was showing the signs which included being sleepy and confused. During an observation and interview on 05/07/24 at 04:56 PM Resident #1 was sitting in a chair next to his bed in the local hospital with a bedside table in front of him. FM B was standing in front of Resident #1 who was eating his dinner from the bedside table. He appeared to be feeding himself easily and was observed drinking from his cup with no assistance. Resident #1 stated he did not remember much about his stay in the facility. He stated he remembered being admitted on [DATE] and put in a wheelchair. When asked if he had a history of getting dehydrated, he said he did but not of passing out from dehydration. FM B stated when he left Resident #1 in the facility on 05/01/24 Resident #1 was doing well and thinking clearly. He stated Resident #1 was living in an assisted living facility prior to his hip surgery and subsequent admission to the facility. He stated Resident #1 had never had issues with confusion prior to his admission to the facility. During an interview on 05/08/24 at 08:31 AM HRN stated Resident #1 was admitted to the hospital's ICU floor under her care on 05/04/24. She said at the time he was admitted he was slurring his speech, could not maintain O2 saturation without supplemental O2 at 2 lpm, was pale in color, had very low blood pressure, and very little urine output. She said he would attempt to say a word on occasion and his speech was incomprehensible. HRN stated she did not work on 05/05/24 and when she returned to work on 05/06/24 Resident #1 was completely different. She stated, Oh my goodness! It was a 360 turn. HRN said Resident #1 no longer needed supplemental O2, his blood pressure was better, his urine output was normal, his color was normal, and he was joking and have full conversations with staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/08/24 at 08:36 AM Resident #1 was in his bed in the hospital on his back with HOB raised to sitting position and a tray table over the bed in front of him holding his breakfast. Resident #1 was feeding himself breakfast. FM B was seated next to the bed and FM C was standing in front of Resident #1. FM C stated when he was visiting Resident #1 in the facility on 05/03/24 Resident #1 was very confused and did not know where he was. He stated once Resident #1 drank some fluids he came around. FM C described Resident #1's condition when he was admitted to ICU on 05/04/24 as scary. During an interview on 05/08/24 at 10:57 AM FM A stated Resident #1 was not taking antidepressant medication prior to his stay in the facility, to her knowledge. She stated, I don't remember him taking antidepressants, he has never been depressed. During an interview on 05/08/24 at 01:21 PM MD stated Resident #1 taking four times the prescribed dose of Amitriptyline the three nights he was in the facility might have affected him going to the hospital. MD also stated due to the sudden nature of Resident #1's decline in condition it could also have been a cardiac event. He stated Amitriptyline was an antidepressant and had sedating qualities and could make you tired. He stated he spoke to LVN when he discovered the medication order had been entered incorrectly in the EHR. MD stated LVN told him he (LVN) made a mistake when he was entering the order into the EHR. During an interview on 05/08/24 at 02:03 PM DON stated the charge nurse on duty was responsible for entering orders into the EHR when a resident was admitted . She stated the next shift charge nurse was supposed to review the orders to ensure they were correct. She stated she had noticed that was not happening so recently she had a meeting with her nurses and told them after the second shift reviews the orders, they needed to give her a report so she could review them a second time and ensure they were correct. She stated the charge nurse admitting Resident #1 was LVN. She stated a possible negative outcome of receiving four times the prescribed amount of Amitriptyline was adverse side effects; increased sedation. During an interview on 05/21/24 at 10:22 AM LVN stated he made a mistake when he was entering Resident #1's order for Amitriptyline into the EHR. He stated on the morning of 05/01/24 Resident #1 was assessed and his blood pressure and oxygen saturation were within normal limits. He sated Resident #1 was alert and oriented at the time of the assessment. LVN stated Resident #1 ate 100% of his breakfast that morning and a CNA took him back to his room where he was talking with another resident. LVN stated there was a pretty sudden change in Resident #1's condition because when his family came to visit, they thought he was asleep and asked LVN to lay him down in his bed. LVN stated when he entered Resident #1's room to help lay him down Resident #1 was not responsive and LVN called the ambulance at that time. Record review of facility policy titled Admission Assessment and Follow Up: Role of the Nurse and dated September 2012 revealed the following: . 7. Conduct an admission assessment (history and physical), including: . d. Current medications and treatments. Reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Administering Medications and dated April 2019 revealed the following: . Medications are administered . as prescribed. 4. Medications are administered in accordance with prescriber orders, . Record review of facility policy titled Medication and Treatment Orders and dated July 2016 revealed the following: . Orders for medications and treatments will be consistent with principles of safe and effective order writing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47854 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communication diseases and infections for 1 (Resident #2) of 5 Residents in that: - The facility failed to ensure CNA performed hand hygiene during foley catheter care for Resident #2. -The facility failed to ensure CNA and HA donned PPE before entering Resident #2's room who was on EBP's. (Enhanced Barrier Precautions). -The facility failed to provide staff with adequate PPE. These failures had the potential to affect residents in the facility by placing them at risk of contracting, spreading, and/or exposing them to bacterial or viral infections that could lead to the spread of communicable diseases. Findings included: During an observation on 05/08/2024 at 10:03am revealed foley catheter care for Resident #2. Care was provided by CNA and HA. CNA and HA performed HH at the beginning of care. CNA started to clean Resident #2's penis, the foley was secured by CNA so that no pulling took place. The meatus of penis was cleaned, and foreskin was retracked with no discomfort for resident. Once shaft of penis was cleaned the foley catheter was cleaned starting at the meatus and down towards the bag of the catheter. This action was done 3 times with clean wipes every time. CNA did not remove gloves or perform HH before placing a brief back on the resident or pulling up his short. CNA then pulled blankets back up on top of resident with the same gloves that she performed foley catheter care with. Resident #2 was left in a comfortable position and HH was performed by HA and CNA before leaving the room. During an interview on 05/08/2024 at 10:11am with CNA when asked about HH, CNA stated, Oh, my goodness, I didn't did I? CNA stated that the negative outcome of not performing HH and a glove change would lead to an increased risk for an infection for the resident. Record review revealed an in-service for Enhanced Barrier Precautions (EBP), CNA had not had this training. Training was dated 04/16/2024. HA had signed the in-service. During an interview on 05/08/2024 at 1:04pm DON stated that the EBP protocol was supposed to go into effect on 04/16/2024. DON stated that if the staff member hadn't signed the document then the staff had not read the policy. DON stated that a negative outcome for not performing HH or glove changes in between dirty and clean aspects of incontinent care could lead to the spread of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2024 at 1:24pm HA was asked if she knew what the in-service was for, she stated that it was for residents that have foley catheters that we are supposed to wear gowns and gloves when care was performed for them. CNA was asked why PPE was not worn during catheter care for Resident #2. CNA stated she just forgot. CNA stated that a negative outcome for not wearing PPE for this type of care was the increased risk for infection. During an interview on 05/08/2024 at 1:31pm CNA was asked about the in-service for EBP. When the CNA was asked what the document was she stated, it looks like the schedule. CNA was asked to look at the document. CNA stated, I don't know what that is. CNA stated, I didn't know anything about having to wear PPE until after catheter care was performed for [Resident #2]. CNA was asked what a negative outcome would be for not having PPE during this type of care, she stated it could make them sick. During an interview on 05/08/2024 at 1:55pm DON was asked why there was not any PPE available outside of Resident #2's room for catheter care. DON stated that the staff that is responsible for ordering PPE has told her that there is an issue with supply for PPE items. DON was asked what a negative outcome would be for not having the appropriate PPE for individuals with precautionary measures in place. DON stated, increased risk for the spread of infections. During an interview on 05/08/2024 at 2:00pm RRN was not aware that there was a shortage or issue getting PPE supplies. RRN was asked what a negative outcome with no having the appropriate PPE and not performing HH and glove changes during foley care. RRN stated there was a potential risk for an increased risk for infection. During an interview on 05/08/2024 at 2:21pm RN stated that the facility was very limited on gowns however there were some in the facility. RN stated that a negative outcome for not having the appropriate PPE was that staff could not follow protocol. Record review of facility provided policy titled Handwashing/Hand Hygiene revealed the following: .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . .e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); . .h. Before moving from a contaminated body site to a clean body site during resident care; . Record review of facility provided policy titled, Catheter Care, Urinary, revised August 2022, revealed the following: .18. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. Record review of CMS from the Quality, safety, and oversight group, dated 03/20/2024, revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Healthcare Center	2510 W 24th St Plainview, TX 79072

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact residents care activities regardless of their multidrug-resistant organism status. The approach recommended gown and glove use for residents during specific high-contact resident care activities .EBP are indicated for residents with any of the following: .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .