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	09/20/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26515 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective person-centered care of the resident that meet professional standards of quality care for one of 5 residents (Resident #1) reviewed for baseline care plans. The facility failed to develop a baseline care plan for Resident #1 that included assessment and dressing changes for a surgical wound. This failure could place residents at risk of receiving care that is substandard, unable to meet their needs, or inadequate to prevent complications such as a serious wound infection, wound deterioration, sepsis, or death. Findings include: Record review of Resident #1's clinical record revealed he admitted to the facility on [DATE], was [AGE] years of age with the following diagnoses: orthopedic aftercare of fracture of right femur (broken thigh bone), history of falling, muscle weakness, unsteadiness on feet, malignant neoplasm of prostate (a disease that occurs when malignant cells form in the prostate gland), anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), hyperlipidemia (too high fat levels in the blood), Idiopathic Peripheral Autonomic Neuropathy (a condition that causes damage to the peripheral nerves without a known cause with symptoms that often affect the feet), hypertension (high blood pressure), Atherosclerotic heart disease of native coronary artery (a common heart condition that occurs when plaque builds up in the coronary arteries) and angina pectoris (chest pain) Record review of a Medicare 5-day MDS resident assessment, dated 8/22/24, documented the resident scored 14 of 15 on a mini-mental exam for cognitive awareness which indicated the resident was interviewable, had a surgical wound with no dressing changes. Record review of Physician Orders, dated 8/16/24, revealed there were no wound care orders for Resident #1. Record review of nurses notes, dated 8/16/24 through 9/4/24, during Resident #1's stay at the nursing home, did not document any wound assessments. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Admission Data Collection form, dated 8/16/24, did not document any skin issues for Resident #1. Record review of a Head to Toe Skin Checks form, dated 8/19/24, documented Resident #1 had existing bruises to right forearm, multiple small scabs to right shin and had a dressing to right hip. Record review of a Head to Toe Skin Checks from, dated 8/26/24, documented Resident #1 had existing bruises to right forearm, multiple small scabs to right shin - no dressing to right hip documented on this skin check. Record review of Resident #1's baseline care plan, dated 8/18/24, revealed the document did not contain any information about the resident's primary reason for receiving skilled services, which was after care for hip surgery - dressing changes, assessing the wound for any changes and documenting in the clinical record what was found. During an interview on 9/18/24 at 1:20 p.m., the DON stated the baseline care plan should include wound care orders and assessments of those wounds but Resident #1 did not have them in the baseline care plan. During a confidential interview #1 on 9/10/24 at 4:25 p.m., it was stated Resident #1 had orders, when he admitted , to remove the bulky dressing which covered the Dermabond, after three days and leave the Dermabond on the surgical wounds so the site could be assessed. (Dermabond is a skin closure like superglue for the skin). The confidential interview #1 stated on his post-surgical visit, the bulky dressings were present - Resident #1's bulky dressing was dried up and stuck to his buttocks. The confidential interview #1 stated the bulky dressing on Residents #1 was not removed. The confidential interview #1 stated Resident #1 has his bulky dressing on for 18 days. The confidential interview #1 stated the surgical incision was covered by the Dermabond and the wounds were not infected but the physician orders were not followed and the possibility of Resident #1's surgical incision getting infected was elevated. During a telephone interview on 9/11/24 at 2:30 p.m., Resident #1 stated the dressing on his leg was never changed during his stay at the facility. Resident #1 stated the Nurse Practitioner told him that the outer dressing should have been removed after three days and that was not done. Resident #1 stated his hip wound was not infected and everything was fine, but it could have been worse, at his age (95), it could have been very bad. Record review of the policy titled, Care Plans -Baseline, revised 3/2022, revealed the following: A baseline plan of care to meet the resident's immediate health and safety needs is developed for reach resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Initial goals based on admission orders and discussion with the resident /representative. b. Physician orders. c. Dietary orders. d. Therapy services. e. Social Services; and f. PASARR recommendation, if applicable.

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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** 26515 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive 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 and describes the services that are to be furnished to obtain or maintain the resident's highest practicable physical, metal, and psychosocial well-being for 1 of 5 residents (Resident #2) whose comprehensive care plans were reviewed. The facility failed to develop a comprehensive care plan for Resident #2 that included dressing changes, assessing the wound for any changes and documenting in the clinical record what was found. This failure could place residents at risk of receiving care that is substandard, unable to meet their needs, or inadequate to prevent complications such as a serious wound infection, wound deterioration, sepsis, or death. Findings include: Record review of Resident #2's clinical record revealed she admitted to the facility on [DATE], was [AGE] years of age with the following diagnoses: intertrochanteric fracture of left femur (a type of fracture that occurs in the upper part of the thigh bone between the greater and lesser trochanters - most common hip fracture in the elderly), hyperlipidemia (too high fat levels in the blood), essential tremor (a nervous system disorder that causes rhythmic shaking), hypertension (high blood pressure), muscle weakness, chronic kidney disease - stage 3 (a midpoint on the CKD spectrum, where kidneys have mild to moderate damage and are less able to filter waste from the blood), abnormal gait and mobility (abnormal walking pattern) and lack of coordination. Record review of a Medicare 5-day MDS resident assessment, dated 8/27/24, documented Resident #2 scored 12 of 15 on a mini-metal exam for cognitive awareness and was interviewable, had surgical wound with dressing orders. Record review of Physician Orders for Resident #2 indicated Wound Care: Do not remove Dermabond tape on incision: okay to shower. Record review of nurses' notes, from 8/21/24 to 9/3/24, did not document any wound care or assessments for Resident #2. Record review of Resident #2's comprehensive care plan, dated 9/11/24, revealed the document did not contain any information about the resident's primary reason for receiving skilled services, which was after care for hip surgery - dressing changes, assessing the wound for any changes and documenting in the clinical record what was found. (continued on next page)

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(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	During an interview on 9/18/24 at 1:20 p.m., the DON stated the comprehensive care plan should include wound care orders and assessments of those wounds but Resident #2 did not have them in the comprehensive care plan. During a confidential interview #1 on 9/10/24 at 4:25 p.m., it was said Resident #2 had orders, when she admitted , to remove the bulky dressing which covered the Dermabond, after three days and leave the Dermabond on the surgical wounds so the site could be assessed. (Dermabond is a skin closure like superglue for the skin). The confidential interview #1 stated on her post-surgical visit, the bulky dressing was present - Resident #2's bulky dressing was soaking wet and her skin around the surgical incision was excoriated like a bad diaper rash. The confidential interview #1 stated the bulky dressing on Residents #2 was not removed and staff at the nursing home were giving Resident #2 a shower with the bulky dressing still intact. The confidential interview #1 stated Resident #2 had the bulky dressing on for 13 days. The confidential interview #1 stated the surgical incision was covered by the Dermabond and the wounds were not infected but the physician orders were not followed and the possibility of Resident #2's surgical incision getting infected was elevated. During a confidential interview #2 on 9/11/24 at 1:50 p.m., it was said the Resident #2's physician was very upset because when Resident #2 went for her initial checkup after surgery, the dressing on the wound was sopping wet and had never been taken off. The confidential interview #2 stated staff were giving Resident #2 a shower and never covered the dressing up. The confidential interview #2 stated the Nurse Practitioner said Resident #2 had a severe case of diaper rash on her hip but Resident #2's wound was not infected, and Resident #2 was very fortunate the wound was not infected. The confidential interview #2 stated staff never removed the covering over the surgical incision like they should have. Record review of a policy titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, revealed the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. c. Includes the resident's stated goals upon admission and desired outcomes. d. builds on the resident's strength; and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. reflects currently recognized standards of practice for problem areas and conditions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26515 Based on observation, interviews, and record review, it was determined the facility failed to ensure that residents received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan for 2 of 5 residents (Residents #1 and #2) reviewed for Quality of Care. The facility failed to ensure Resident #1's surgical wound was assessed, and wound care orders were received from the hospital upon admission to the facility. Resident #1 had a post-surgery check up on 9/3/24, 18 days after admission and the bulky wound dressing from the surgery was still covering the wound and was dried to his leg but the incision was not infected. The facility failed to ensure Resident #2's surgical wound was assessed, and wound care orders were received from the hospital upon admission to the facility. Resident #2 had a post-surgery check up on 9/3/24, 13 days after admission and the bulky wound dressing from the surgery was still covering the wound and was soaking wet. No infection was present at this time, but the surrounding tissue was excoriated. An Immediate Jeopardy (IJ) was identified on 9/18/24 at 4:15 p.m. While the IJ was removed on 9/20/24 at 2:15 p.m., the facility remained out of compliance at a scope of Isolated with the potential for harm because the facility's need to implement and monitor the effectiveness of its corrective systems. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition, the need for hospitalization or death. Findings include: Resident #1 Record review of Resident #1's clinical record revealed he admitted to the facility on [DATE], was [AGE] years of age with the following diagnoses: orthopedic aftercare of fracture of right femur (broken thigh bone), history of falling, muscle weakness, unsteadiness on feet, malignant neoplasm of prostate (a disease that occurs when malignant cells form in the prostate gland), anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), hyperlipidemia (too high fat levels in the blood), Idiopathic Peripheral Autonomic Neuropathy (a condition that causes damage to the peripheral nerves without a known cause with symptoms that often affect the feet), hypertension (high blood pressure), Atherosclerotic heart disease of native coronary artery (a common heart condition that occurs when plaque builds up in the coronary arteries) and angina pectoris (chest pain) Record review of a Medicare 5-day MDS resident assessment, dated 8/22/24, documented Resident #1 scored 14 of 15 on a mini-mental exam for cognitive awareness and was interviewable, had a surgical wound with no dressing changes. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Physician Orders, dated 8/16/24, revealed there were no wound care orders for Resident #1. Record review of nurses notes, dated 8/16/24 through 9/4/24, during Resident #1's stay at the nursing home, did not document any wound assessments. Record review of an Admission Data Collection form, dated 8/16/24, did not document any skin issues for Resident #1. Record review of a Head to Toe Skin Checks form, dated 8/19/24, documented Resident #1 had existing bruises to right forearm, multiple small scabs to right shin and had a dressing to right hip. Record review of a Head to Toe Skin Checks form, dated 8/26/24, documented Resident #1 had existing bruises to right forearm, multiple small scabs to right shin - no dressing to right hip documented on this skin check. Resident #2 Record review of Resident #2's clinical record revealed she admitted to the facility on [DATE], was [AGE] years of age with the following diagnoses: intertrochanteric fracture of left femur (a type of fracture that occurs in the upper part of the thigh bone between the greater and lesser trochanters - most common hip fracture in the elderly), hyperlipidemia (too high fat levels in the blood), essential tremor (a nervous system disorder that causes rhythmic shaking), hypertension (high blood pressure), muscle weakness, chronic kidney disease - stage 3 (a midpoint on the CKD spectrum, where kidneys have mild to moderate damage and are less able to filter waste from the blood), abnormal gait and mobility (abnormal walking pattern) and lack of coordination. Record review of a Medicare 5-day MDS resident assessment, dated 8/27/24, documented Resident #2 scored 12 of 15 on a mini-metal exam for cognitive awareness and was interviewable, had surgical wound with dressing orders. Record review of Physician Orders for Wound Care for Resident #2: Do not remove Dermabond tape on incision: okay to shower. Record review of nurses notes, from 8/21/24 to 9/3/24, did not document any wound assessments. During an interview on 9/10/24 at 4:25 p.m., a confidential complainant #1 stated both Resident #1 and #2 had orders, when they admitted , to remove the bulky dressing which covered the Dermabond, after three days and leave the Dermabond on the surgical wounds so the site could be assessed. (Dermabond is a skin closure like superglue for the skin). The confidential complainant #1 stated on their post-surgical visits, the bulky dressings were present - Resident #1's bulky dressing was dried up and Resident #2's bulky dressing was soaking wet and her skin around the surgical incision was excoriated. The confidential complainant #1 stated the bulky dressings on Residents #1 and #2 were not removed and staff at the nursing home were giving Resident #2 a shower with the bulky dressing still intact. The confidential complainant #1 stated Resident #1 has his bulky dressing on for 18 days and Resident #2 had the bulky dressing on for 13 days. The confidential complainant #1 stated the surgical incision was covered by the Dermabond and the wounds were not infected but the physician orders were not followed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/11/24 at 9:25 a.m., the MDS Coordinator A stated they do not have a wound care nurse, each nurse does dressing changes for the residents in their care. MDS Coordinator A stated on the weekends, they have an RN who oversees all the dressing changes and care issues. During an interview on 9/11/24 at 9:45 a.m., LVN A stated he does his own dressing changes, and he did not have any surgical dressing changes at this time. During an interview on 9/11/24 at 10:20 a.m., LVN B stated she does wound care on the residents on her hallway. LVN B stated she did not have any surgical wounds on her side of the building at this time. During an interview on 9/11/24 at 11:45 a.m., the DON stated she had never had any complaints about wound care. The DON stated she remembered Resident #1 had a seven-day dressing on and that was left until the resident went back to the surgeon. The DON stated when Resident #1's dressing was taken off at the doctor, the wound was irritated around the wound from the tape. The DON stated they did not have any wound care orders for Resident #1. The DON stated sometimes a resident comes with wound care orders and sometimes they don't. The DON stated if a resident with a surgical wound was admitted to the facility, she would expect the nurse to call the doctor and get orders for wound care. The DON stated Resident #2 had hip surgery also and was admitted with wound care orders, but the order was just to not remove the Dermabond. The DON stated the nurse on duty does the admission assessment and would document any skin issues. The DON stated LVN A was the nurse that did Resident #2's initial assessment and he would know more about the wound care orders. During a follow-up interview on 9/11/24 at 12:15 p.m., LVN A stated Resident #2 had a dressing on her hip when she admitted but there were no orders to take the dressing off. LVN A stated the doctor usually does not take anything (dressings) off until after the first visit back to the doctor. LVN A stated when a resident admits with a wound, the nurse needs to call the doctor for orders because PT does the wound care at the hospital. LVN A stated they typically do not take off any surgical wound dressings until the resident has seen the surgeon. LVN A stated he should have called the physician and double checked the wound care orders for Resident #2. During a confidential interview #2 on 9/11/24 at 1:50 p.m., it was said the Resident #2's physician was very upset because when Resident #2 went for her initial checkup after surgery, the dressing on the wound was sopping wet and had never been taken off. The confidential interview #2 stated staff were giving Resident #2 a shower and never covered the dressing up. The confidential interview #2 stated the Nurse Practitioner said Resident #2 had a severe case of diaper rash on her hip but Resident #2's wound was not infected, and Resident #2 was very fortunate the wound was not infected. The confidential interview #2 stated staff never removed the covering over the surgical incision like they should have. During a telephone interview on 9/11/24 at 2:30 p.m., Resident #1 stated the dressing on his leg was never changed during his stay at the facility. Resident #1 stated the Nurse Practitioner told him that the outer dressing should have been removed after three days and that was not done. Resident #1 stated his hip wound was not infected and everything was fine, but it could have been worse, at his age (95), it could have been very bad. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/12/24 at 11:30 a.m., the Administrator stated staff should have called for wound care orders for Residents #1 and #2 when they were admitted if they did not have orders with them. The Administrator stated staff did not call to get wound care orders for either resident, but they should have. An observation on 9/12/24 at 12:00 p.m., of Resident #2's surgical incision on her hip revealed the incision was across her lower left buttock, was healing and was pink around the edges. The pink color went around the edges of the incision site for about 3 to 4 inches. During a follow-up interview on 9/17/24 at 9:05 a.m., the confidential complainant #1 was informed that the facility did not receive wound care orders when Resident #1 and #2 admitted to the facility. The confidential complainant #1 stated the orders were written and given to the van driver who picked up the residents at the hospital. The confidential complainant #1 stated if a resident admitted with no orders for wound care, it would be nursing 101 for the nurse on duty to call the physician or nurse practitioner for wound care orders at that time. During an interview on 9/18/24 at 10:55 a.m., RN C stated she works every weekend and does wound care for residents with orders. RN C stated Resident #1 and Resident #2 did not have any wound care or dressing changes ordered so there was no wound care completed for those two residents. RN C stated she did check both resident's dressings to make sure they were clean, but she never removed any dressings because there were no orders for removing a dressing or changing a dressing. RN C stated she felt she was the only nurse in the facility that looked at any wounds because the DON doesn't do it. RN C checked PCC for any documentation or assessments in the computer and there was not any documentation for Resident #1 or Resident #1. RN C stated she was thinking about leaving the facility due to the lack of leadership. Record review of a policy titled, Admission Assessment and Follow up: Role of the Nurse revealed the following: Purpose: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. 8. Conduct a physical assessment, including the following systems: j. skin: 1. All wounds or surgical incisions should be looked at and documented. Nurse must ensure that there are any wound care orders, and if not, then MD or physician that completed the surgery must be contacted for any wound care orders day of admission and documentation should be charted on who was contacted and the orders given. 12. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The facility was notified an Immediate Jeopardy was identified on 9/18/24 at 4:15 p.m. and the Immediate Jeopardy templates were provided to the Facility's Administrator and a Plan of Removal was requested. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following Plan of Removal was submitted on 9/19/24 at 3:10 p.m. and accepted on 9/19/24 at 3:20 p.m. Plan of Removal for F 684 A. This deficient practice will be corrected. Chart reviews have been completed for all residents that have wounds to ensure that they have orders. Dressing changes and assessments have been documented in the resident's clinical record. Wound care has been completed and wound care orders for the residents were followed per the physician orders. Nursing staff has been re-educated and in-serviced on ensuring residents have wound orders for surgical wounds on admission, assessment, and documentation of wound/skin in PCC every shift, informing the physician of any changes as needed. B. This deficient practice has the potential to affect all residents. C. IDT/Nursing staff has been re-educated and in-serviced on ensuring residents have wound orders for surgical wounds on admission, assessment, and documentation of wound/skin in PCC every shift, informing physician of any changes as needed. D. DON/Designee will monitor assessment of skin documentation and assist in physician notification of any changes and to ensure orders are obtained for any wounds. Administrator will have oversight. QAPI committee will monitor monthly until compliance is assured. Will be done by 9/19/24. On 9/20/24 at 8:00 a.m., the surveyor confirmed the Plan of Removal was sufficiently implemented by: 1. During the interviews that occurred on 9/20/24 starting at 10:20 a.m. and ending at 2:00 p.m., nursing staff were able to describe what steps to follow when a resident was admitted with a wound dressing and no orders. On admission to the facility, every resident's skin will be assessed from head to toe for any kind of skin issues or surgical incisions. If a resident was admitted to the facility with any kind of a wound and had no orders for care and dressing changes (if needed), the physician or nurse practitioner would be contacted to obtain orders. Wound care orders would be placed on the TAR and immediately implemented. Documentation should be charted in the clinical record who was contacted for orders and the orders given. The wounds would be assessed every shift for any changes of the wound and the physician or nurse practitioner would be informed of changes. 2. Interviews conducted with nursing staff working at the facility on 9/20/24: Administrator, DON, LVN A. RN C, LVN D, LVN E, MDS Coordinator B. Telephone interviews with staff on 9/20/24: MDS Coordinator A and LVN F, G, H, I J, and K. All staff were interviewed on all shifts. (NOTE: During a follow-up interview on 9/20/24 at 2:00 p.m., the DON stated LVN B was let go earlier this week and RN C just gave her resignation so as of today, she was the only RN left working in the facility. The DON stated the facility has 7 full times nurses, 3 PRN nurses and agency staff were always in the facility. The DON stated they advertise for nurses all the time, but no one wants to work. (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	09/20/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Record review of the in-service sheets reflected all nursing staff had been trained on the facility's Daily Documentation Guidelines - when a resident is skilled, please document on the topics as listed below every shift, and Wound Assessment and Documentation. An Immediate Jeopardy (IJ) was identified on 9/18/24 at 4:15 p.m. While the IJ was removed on 9/20/24 at 2:15 p.m., the facility remained out of compliance at a scope of Isolated with the potential for harm because the facility's need to implement and monitor the effectiveness of its corrective systems.