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	07/01/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure the freezer, refrigerator, and pantry items were properly stored, labeled, and dated.This failure could place residents at risk of food-borne illnesses. Findings included: Observation of the prep area in the kitchen on 06/29/26 at 9:25 AM revealed the following:1. (3) clear bins containing individual cereal bowls were not labeled or dated. Observation of the walk-in refrigerator on 06/29/26 at 9:27 AM revealed the following:1. (1) box of vegetables, no label or date. 2. (1) bag that contained half of a cut lemon in a foam bowl, no label or date.3. (4) bags of fresh grapes, open to air, and 1 bag contained moldy grapes.4. (1) tray of fruit cups, covered, no label, and the date was unreadable.5. (1) box of cupcakes, not sealed, no label or date. 6. (1) box containing tortillas, no label or date. Observation of the freezer on 06/29/26 at 9:33 AM revealed the following:1. (4) large trays with individual foam bowls containing what looked to be ice cream, all open to air, not labeled or dated.2. (1) bag of patties, no label or date.3. (1) bag of chicken patties, open to air.4. (1) bag of meat, label unreadable, dated. Observation of the pantry on 06/29/26 at 9:37 AM revealed the following:1. (1) powdered Kool-Aid package, open to air, dated and labeled.2. (1) large clear container of rice, lid was not on, and rice was open to air.During an interview on 06/29/26 at 9:48 AM, the DM stated it was everyone's responsibility to label and date food and if that did not happen, they could serve outdated food to residents and they could get sick. During an interview on 06/29/26 at 9:51 AM, [NAME] A stated she had worked at the facility for 9 years and everyone who worked in the kitchen was responsible for labeling and dating food. She stated if that did not happen, residents could become sick from eating bad food. During an interview on 06/29/26 at 10:01 AM, [NAME] B stated it was everyone's responsibility to label and date food and if that was not happening, the kitchen could serve bad food which could make residents sick.In an interview on 06/10/26 at 10:40 AM, [NAME] C stated he had worked at the facility for 5 years and that it was everyone's responsibility to label and date food and that if it was not done, kitchen staff would not know if food was outdated and it could put residents at risk of getting sick. Record review of facility policy, titled Nutrition Policies and Procedures, Subject: Safe Food Handling dated October 2009, revealed the following information in part.3. All foods are stored in a closed container or tightly wrapped package and labeled with the common name of the item and dated. 5. Leftover foods are properly covered, labeled and dated.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 12 residents (Residents #2 and #3), and 1 of 2 staff members observed for infection control. LVN C failed to ensure infection control with wrist blood pressure cuff and did not clean it between use of residents. The facility failed to ensure Resident #3's catheter bag was not dragging on the floor. C.N.A. E failed to ensure infection control by not changing gloves prior to starting pericare for Resident #3. C.N.A. F failed to ensure infection control by not changing glovers prior to catheter care for Resident #3. C.N.A. G failed to ensure infection control by not changing gloves prior to starting pericare for Resident #2. This deficient practice could put residents at risk for increased infections. Findings include: During observation of medication pass on 06/30/2026 at 7:05 am, LVN C had taken a blood pressure for a resident in RM [ROOM NUMBER]. LVN C laid the blood pressure cuff on top of medication cart. LVN C prepared medications for RM #121. LVN C took the resident's blood pressure with the same wrist blood pressure cuff without cleaning it after the last resident. LVN C laid the blood pressure cuff on top of the cart without cleaning the cuff. LVN C prepared medications for RM #127. LVN C took the blood pressure of the resident in RM #127 with the same wrist blood pressure cuff, without cleaning between residents. During an interview with LVN D on 06/30/2026 at 8:10 am, LVN D stated that they cleaned the pulse oximeters and glucometers with alcohol, but they could not clean the blood pressure cuffs because they were cloth. During an interview with LVN C on 06/30/2026 at 2:18 pm, she stated she cleaned the pulse oximeter, but failed to clean her blood pressure cuff. LVN C stated she knew better, and just failed to do so. A negative effect of not cleaning between resident is cross contamination. Resident #3 Record review of Resident #3's face sheet printed 06/29/2026 revealed an [AGE] year-old male. Resident #3 was admitted on [DATE] with the following diagnoses: acute blood clot of unspecified deep veins of lower extremities bilateral, fluid overload (too much fluid in your body), acute on chronic diastolic congestive heart failure (heart left ventricle becomes stiff and fails to relax properly), difficulty walking, and muscle weakness. Resident # 3's Quarterly MDS, dated [DATE] revealed a BIMS of 13 out of 15 indicating no cognitive impairment. His functionality on his last MDS revealed he required substantial/maximal assistance to complete toileting and transfers. Resident #3 required the use of a catheter. Care Plan dated 03/24/2026 revealed Resident #3 was totally dependent on staff for transfers, toileting, dressing and bathing. The Care Plan revealed: The resident has a 16 fr with a 10 ml retention balloon indwelling Foley connected to bedside drainage resident required a catheter. Date initiated 09/09/2023 Revised on 06/22/2026. Interventions on the care plan revealed position catheter bag and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tubing below the level of the bladder and away from the entrance room door. Check tubing for kinks each shift. Change monthly. Record review of Resident #3's physician's orders dated 06/29/2026, revealed: Catheter care every shift Start: 10/02/2023 EBP due to Foley catheter every shift. Start: 06/30/2025. During an observation on 06/30/2026 at 7:50 am Resident #3 's catheter bag was observed on the floor of the dining room under the resident chair. Resident #3 was observed wheeling himself from the dining room down the hall to his room with the catheter bag dragging on the floor under his wheelchair. During an incontinence care observation on 06/30/2026 at 9:30 am for Resident #3, revealed C.N.A. E and C.N.A. F put on PPE due to EBP precautions, washed their hands and put on gloves. The C.N.A.'s removed the blanket from Resident #3, assisted Resident #3 to turn to his left side so they could pull down his pants, then assisted him back to his back, and opened his brief. C.N.A. E, then started pericare without changing her gloves. When C.N.A. E, completed peri-care she stepped back and did not remove her gloves. C.N.A. F, then performed catheter care without changing his gloves. During an interview with C.N.A. E and C.N.A. F on 06/30/2026 at 1:39 pm, the both reported they should have changed gloves prior to starting pericare and catheter care. C.N.A. F voiced that a negative outcome of not changing gloves prior to performing pericare or catheter care could cause infection. During an interview on 07/01/2026 at 8:39 am, CNA H stated she had not been aware Resident #3's catheter bag had been on the floor. She stated the bag should have been secured to the chair and not dragging on the ground. She stated the consequences for not securing the bag were germs. She stated she had been trained for her job by a lot of different people. During an interview on 07/01/2026 at 9:04 am, LVN I stated he had not been aware Resident #3 had his catheter bag on the floor in the dining room. He stated this was an infection control issue and the bag should have been attached securely to his chair. He stated he had been trained in infection control practices by the DON. He stated the consequences of having a bag on the floor were infection to the residents. During an interview on 07/01/2026 at 9:23 am the DON stated she expected staff to follow best practices and expected catheter bags to be secured and not dragging on the floor. She stated she tried to work with the staff to ensure they do what needed to be done. She stated the consequences of the bag dragging on the floor were infection control issues and created unsanitary conditions. She stated she had trained the staff in infection control practices, and she had also been trained in infection control practices by the former DON. Resident #2 Record review of Resident #2's face sheet printed on 07/01/2026, revealed a [AGE] year-old female that admitted to the facility on [DATE] with a readmission on [DATE] with the following diagnosis: heart failure (heart muscle too weak or stiff to pump enough blood to meet your body's needs), hypertension (the force of blood against your artery walls is consistently too high), dysphagia (language disorder caused by brain damage that impairs a person's ability to speak, understand, read, or write), Parkinson's disease with dyskinesia (progressive neurological disorder that damages (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dopamine-producing brain cells- involuntary muscle movement) , and dementia (decline in mental ability). Record review of Resident #2's Quarterly MDS dated [DATE], revealed a BIMS of 2 out of 15 indicating a severe cognitive impairment. Resident #2 requires substantial/maximal too dependent physical assistance for functional abilities. Resident #2 is dependent for toileting hygiene. Resident #2 was always incontinent of bladder and bowel. Record review of Resident #2's Care Plan dated 05/06/2026 revealed Resident #2 required total assistance of one staff for toileting. Resident #2 has bowel and bladder incontinence related to her cognition decline and forgetfulness. Record review of Resident #2's physician's orders as of 07/01/2026 revealed Resident #2 is incontinent of bowel and bladder and wears brief/pullup. During an incontinence care observation on 06/30/2026 at 11:01 am, for Resident #2. Revealed C.N.A. G washed his hands and put on gloves. C.N.A. G raised bed to working height, removed Resident #2's blanket and undid Resident #2's brief. C.N.A. G proceeded with pericare without changing his gloves. During an interview with the DON on 06/30/2026 at 1:27 pm she reported that she used a skills checklist for peri-care; that they do upon hire and annually. The DON stated that she expected her staff to follow infection control procedures. The DON voiced that staff should remove their gloves and perform hand hygiene after touching resident's bedding, prior to starting peri-care. The DON stated that staff should be cleaning multiuse equipment, including the wrist blood pressure cuffs, with alcohol or the Sani-wipes. The DON stated that a negative outcome of not following the infection control guidelines could result in cross-contamination or infections. The DON presented a copy of her checklist that she used. The DON reviewed the checklist and stated a step was missed between getting the resident ready and starting peri-care. The DON voiced that she would update the checklist and put the step in to remove gloves and utilize hand hygiene after preparing the resident for care. The DON stated staff should put on a clean pair of gloves prior to starting peri-care. The DON stated that she just went over the checklist with the staff, and if she had not, they probably would not have missed that step. During an interview with C.N.A. G on 06/30/2026 at 2:30 p.m. regarding the observation of peri-care for Resident #2 revealed that C.N.G. did not agree with the observation. C.N.A. G voiced that he followed the checklist and he had just changed the resident's bedding that morning. C.N.A. G voiced that all he could say was, Ok. During an interview with the DON on 07/01/2026 at 8:53 am revealed that she had talked to C.N.A. G the day before regarding pericare. The DON reported that C.N.A. G did understand that raising the bed and removing the blanket and brief contaminated his gloves, and that he should utilize hand hygiene and put on a clean pair of gloves. During an interview with the ADM on 07/01/2026 at 9:50 am regarding the infection control issues identified during survey revealed the ADM shook her head no, and stated that staff needed to change their gloves after preparing the resident for care. The ADM also stated that all multi-use equipment should be cleaned after each resident to prevent cross contamination and potentially an infection. Record review of the facility policy titled Policies and Practice- Infection Control dated October 2018, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the facility infection control policies and practices apply to all personnel, consultants, residents , visitors and the general public. The objectives of our infection control policies and practices are to maintain a safe sanitary comfortable environment. Record review of the facility policy titled, Standard Precautions, revised September 2022: Policy Statement: Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 2. Gloves d. Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care. f. Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one). h. Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. Record review of the facility policy titled, Catheter Care, Urinary revised August 2022: Purpose: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. General Guidelines: Infection Control: 2. Be sure the catheter tubing and drainage bag are kept off the floor. Record review of the facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment revised September 2022: Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. 1 c. Non-critical items are those that come in contact with intact skin but not mucous membranes. Non-critical resident-care items include bed pans, blood pressure cuffs, crutches, and computers. Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturer's instructions. Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. Record review of the Staff Education/Orientation Policies and Procedures checklist- Discipline: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing. Competency: Peri-Care. Revision 07/01/2013. Performance Criteria: 4. Washes hands, applies disposable gloves and PPE as indicated. 5. Assembles supplies at bedside. 6. Raise head of bed to comfortable working height; assists the patient/resident to a supine position. FEMALE 7. Positions waterproof pad under buttocks or places bedpan under buttocks. 8. Helps to flex knees and spread legs apart. Notes limitation in positioning. 9. Cleans the upper thighs. All personnel will be trained on infection control policies and practices upon hire and periodically thereafter.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that meet professional standards of quality and that included measurable objectives and time frames for 1 of 11 (Residents #3) Residents reviewed for care plans.A. The facility failed to ensure Resident #3's daily use of compression socks had been care planned. There was no documentation in the care plan of measurable objectives, interventions, or timeframes for how staff would meet this need.This failure to accurately develop and implement a care plan could result in staff not being aware of critical treatment-related risks and monitoring needs, placing residents at risk for delayed treatment and failure to provide necessary care and services. Findings include:Record review of Resident #3 ?s face sheet printed 06/29/2026 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of embolism (a traveling mass of undissolved matter such as a blood clot) deep vein thrombosis of lower extremities bilateral (blood clot in deep vein of legs), fluid overload (when body retains too much fluids), acute on chronic diastolic congestive heart failure (decompensation that causes fluid to quickly back up to the lungs), difficulty walking, and muscle weakness. Record review of Resident # 3's Quarterly MDS, dated [DATE] revealed a BIMS of 13 out of 15 indicating no cognitive impairment. The MDS revealed he required substantial/maximal assistance to complete toileting and transfers. Resident # 3 was totally dependent on staff for putting on and taking off footwear. Record review of the Care Plan dated 3/24/26 documented Resident # 3 was totally dependent on staff for transfers, toileting, dressing and bathing. The Care plan documented Resident #3 was on diuretic therapy related to edema. The Goal listed revealed Resident will be free of discomfort or side effects of diuretic therapy through the review date. Interventions include administering diuretic medications as ordered. Monitor for side effects. There was no mention of the compression socks listed in the care plan for any task.Record review of Resident # 3's physician's orders dated 6/29/26, documented Wear BLE (Bilateral Lower Extremities) above the knee compression stockings while awake every dayshift for edema. Order start date was 05/15/25 with no discontinue date.Record review of Treatment Administration Record on 7/1/26 revealed compression socks were documented as being placed on Resident # 3 on 6/29/26, 6/30/26 and 7/1/26 in the am when observations and interviews stated otherwise.In an Observation and Interview on 6/29/26 at 9:30 am revealed Resident # 3 was sitting in his recliner in his room, and there were no compression socks observed on his legs. Resident #3 stated, I am supposed to have compression socks on. I usually have to tell the staff to put them on. I usually tell them around 10:30 am because I know they are busy and they had not put them on yet. I need to wear them. I am at risk of getting blood clots if I do not have them on when I am up. Resident #3 stated he was usually up by 6 am and sitting in his wheelchair to go eat breakfast in the dining room. He stated after breakfast he liked to sit in his recliner in his room. He stated he liked to go to bed at 8 pm. He stated he was dependent on staff for catheter care, transferring to chair from his bed and getting the compression hose on. He stated he could not put the compression socks on his legs without staff assistance. He stated the staff rarely put the compression socks on first thing when he gets up and he knows they are busy, so he waits. He stated by around 10 :00 am, if the staff still had not put the compression socks on he will tell the staff he needs the socks on his legs. He stated he was supposed to have them put on when he got up at 6 am and into his chair. He stated he could not get up from his chair to the bed without staff assistance. In an Observation on 6/29/26 at 11:25 am revealed Resident # 3 was sitting in his wheelchair in the dining room waiting for the lunch meal. Resident #3 had no compression socks on his legs. In an Observation and Interview on 6/29/26 at 2:00 pm revealed Resident # 3 was sitting in his wheelchair in his room, and there were no compression socks on his legs. He stated he had not told the staff he needed the socks to be put on. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He stated he thought the staff would have put the socks on by now. In an interview on 6/29/26 at 3:30 pm Resident #3 stated the staff put the compression socks on his legs around 2:30 pm.In an observation on 6/30/26 at 7:05 am Resident #3 was in his wheelchair in the dining room waiting for breakfast. Resident #3 had no compression socks on his legs. In an observation on 6/30/26 at 7: 50 am Resident #3 was in his wheelchair in the dining room. Resident #3 had no compression socks on his legs. In an observation on 6/30/26 from 11:40 am to 12:45 pm, Resident #3 was in his wheelchair in the dining room. Resident #3 had no compression socks on his legs. In an observation on 7/1/26 at 7:55 am Resident #3 was observed in the dining room with no compression socks on his legs. In an observation and interview on 7/1/26 at 8:20 am Resident #3 was observed in his room in his with no compression socks on his legs. Resident #3 stated he had been up in his wheelchair since 6 am. In an Interview on 7/1/26 at 8:40 am, CNA H stated she was aware Resident #3 had compression socks and that he needed to wear them daily. She stated Resident #3 did not like to wear compression socks and also stated Resident #3 usually called staff to put them on around 10:00 am. She stated the staff waited to put the compression socks on until the resident called for them. When asked what the care plan and physician orders said she stated she did not know because she did not look at the orders or the care plan. She stated the consequences for not putting the compression socks on for the resident would be swelling in his legs and he retained a lot of water. She stated she had been trained for her job by a lot of different people. In an interview on 7/1/26 at 9:05 am, LVN I stated he had been aware Resident #3 had an order for compression socks to be on in the day and off at night. He stated he was not aware Resident #3 had not had the socks put on until late in the afternoon. He stated the CNAs usually put the compression socks on and he did not know why they had not done that when the resident had gotten up in the morning. He stated when the physician order says during the day that meant when the resident gets up at 6 am, the CNAs should put the hose on Resident #3. He stated he monitors the CNAs work to make sure the CNAs are providing adequate care. LVN I stated the compression socks should have been in the care plan and he was not sure if the socks had been care planned. He stated the consequences of not having the socks care planned would be poor treatment and care. He stated the consequences of Resident #3 not wearing compression socks would be swelling, edema or blood clots. In an Interview on 7/1/26 at 9:30 am, the DON stated she expected all staff to follow the physicians' orders. She stated that an order would be put into the charting system after it is written by a physician and would be listed on the Treatment Administration Record. She stated the staff were supposed to record the treatment activities as they had occurred. The DON stated she was not aware Resident # 3 had not had his compression socks on in the mornings. She stated she had trained the nursing staff to do their jobs and expected physicians' orders were followed 100 percent for all orders and all residents. The DON stated she expected the compression socks to be listed in the care plan. She stated the consequences of not wearing the compression socks for a resident would be blood clots and circulation issues. She stated the consequences of not having the compression socks care planned would be treatments not being done. In an Interview on 7/1/26 at 9:40 am, CNA J stated she was aware Resident #3 had compression socks and that he needed to wear them daily. She stated the CNAs usually put the compression socks on him around 10:00 am if he wanted them on. When she was asked what the physician order, care plan or the TAR said about the socks, she did not know. When asked what wear socks while awake meant, she said she thought it meant put the socks on before 10:00 am and taking them off before bed. She stated the consequences for not putting the compression socks on for the resident would be swelling in his legs. Record Review of the facility policy dated March 2022 titled Care Plans, Comprehensive - Person Centered revealed: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet resident needs is developed and implemented for each resident. The care plan interventions from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice for 1 of 11 residents (Resident #3) reviewed for physician orders for treatments. The facility failed to follow physician orders and apply Compression socks as ordered for Resident # 3. The failure could affect residents currently residing in the facility resulting in not receiving needed care to maintain optimum health and placing them at risk for injury and/or deterioration in their condition. Findings include:Record review of Resident #3 ?s face sheet printed 06/29/2026 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of embolism (a traveling mass of undissolved matter such as a blood clot) deep vein thrombosis of lower extremities bilateral (blood clot in deep vein of legs), fluid overload (when body retains too much fluids), acute on chronic diastolic congestive heart failure (decompensation that causes fluid to quickly back up to the lungs), difficulty walking, and muscle weakness. Resident # 3's Quarterly MDS, dated [DATE] revealed a BIMS of 13 out of 15 indicating no cognitive impairment. The MDS revealed he required substantial/maximal assistance to complete toileting and transfers. Resident # 3 was totally dependent on staff for putting on and taking off footwear. Record review of Resident #3's Care Plan dated 3/24/26 documented Resident # 3 was totally dependent on staff for transfers, toileting, dressing and bathing. Record review of Resident # 3's physician's orders dated 6/29/26, documented Wear BLE (Bilateral Lower Extremities) above the knee compression stockings while awake every dayshift for edema. Order start date was 05/ 15/25 with no discontinue date. Record review of Treatment Administration Record on 7/1/26 revealed compression socks were documented as being placed on Resident # 3 on 6/29/26, 6/30/26 and 7/1/26 in the mornings when observations and interview stated otherwise. In an Observation and Interview on 6/29/26 at 9:30 am revealed Resident # 3 was sitting in his recliner in his room, and there were no compression socks observed on his legs. Resident #3 stated, I am supposed to have compression socks on. I usually have to tell the staff to put them on. I usually tell them around 10:30 am to put the socks on because I know they are busy in the mornings. I need to wear them. I am at risk of getting blood clots if I do not have them on when I am up. Resident #3 stated he was usually up by 6 am and sitting in his wheelchair to go eat breakfast in the dining room. He stated after breakfast he liked to sit in his recliner in his room. He stated he liked to go to bed at 8 pm. He stated he was dependent on staff for catheter care, transferring to chair from his bed and getting the compression hose on. He stated he could not put the compression socks on his legs without staff assistance. He stated the staff rarely put the compression socks on first thing when he gets up and he knows they are busy, so he waits. He stated by around 10:00 am the staff still have not put the compression socks on he will tell them. He stated he was supposed to have them put on when he got up at 6 am and into his chair. He stated he could not get up from his chair to the bed without staff assistance. In an Observation on 6/29/26 at 11:25 am revealed Resident # 3 was sitting in his wheelchair in the dining room waiting for the lunch meal. Resident #3 had no compression socks on his legs. In an Observation on 6/29/26 at 2:00 pm revealed Resident # 3 was sitting in his wheelchair in his room, and there were no compression socks on his legs. In an interview on 6/29/26 at 3:30 pm Resident #3 stated the staff put the compression socks on his legs at 2:00 pm. He stated the compression hose were put on his legs on 6/28/29 around 2:30 pm. In an observation on 6/30/26 at 7:05 am Resident #3 was in his wheelchair in the dining room waiting for breakfast. Resident #3 had no compression socks on his legs. In an observation on 6/30/26 at 7: 50 am, Resident #3 was in his wheelchair in the dining room. Resident #3 had no compression socks on his legs. In an observation on 6/30/26 at 11:40 am to 12:45 pm, Resident #3 was in his wheelchair in the dining room. Resident #3 had no compression socks on his legs. In an observation on 7/1/26 at 7:55 am Resident #3 was observed in the dining room with no compression socks on his legs. In an observation and interview on 7/1/26 at 8:20 am (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	07/01/2026

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was observed in his room in his with no compression socks on his legs. Resident #3 stated he had been up in his wheelchair since 6 am. In an Interview on 7/1/26 at 8:40 am, CNA H stated she was aware Resident #3 had compression socks and that he needed to wear them daily. She stated Resident #3 did not like to wear compression socks and also stated Resident #3 usually called staff to put them on around 10:00 am. She stated the staff waited to put the compression socks on until the resident called for them. When asked what the care plan and physician orders said she stated she did not know because she did not look at the orders or the care plan. She stated the consequences for not putting the compression socks on for the resident would be swelling in his legs and he retained a lot of water. She stated she had been trained for her job by a lot of different people. In an interview on 7/1/26 at 9:05 am, LVN I stated he had been aware Resident #3 had an order for compression socks to be on in the day and off at night. He stated he was not aware Resident #3 had not had the socks put on until late in the afternoon. He stated the CNAs usually put the compression socks on and he did not know why they had not done that when the resident had gotten up in the morning. He stated when the physician order says during the day that meant when the resident gets up at 6 am the CNAs should put the hose on Resident #3. He stated he monitors the CNAs work to make sure the CNAs are providing adequate care. He stated the consequences of Resident #3 not wearing compression socks would be swelling, edema or blood clots. In an Interview on 7/1/26 at 9:30 am, the DON stated she expected all staff to follow the physicians' orders. She stated that an order would be put into the charting system after it is written by a physician and would be listed on the Treatment Administration Record. She stated the staff were supposed to record the treatment activities as they had occurred. The DON stated she was not aware Resident # 3 had not had his compression socks on in the mornings. She stated she had trained the nurses to do their jobs and expected all staff to follow physicians' orders 100 percent for all orders and all residents. The DON stated she expected the compression socks to be listed in the care plan. She stated the consequences of not wearing the compression socks for a resident would be blood clots and circulation issues. She stated the consequences of not having the compression socks care planned would be treatments not being done. In an Interview on 7/1/26 at 9:40 am, CNA J stated she was aware Resident #3 had compression socks and that he needed to wear them daily. She stated the CNAs usually put the compression socks on him around 10:00 am if he wanted them on. When she was asked what the physician order, care plan or the TAR said about the socks, she did not know. When asked what wear socks while awake meant, she said she thought it meant put the socks on before 10:00 am and taking off before bed. She stated the consequences for not putting the compression socks on for the resident would be swelling in his legs. Record Review of the facility policy titled Medications and Treatment Orders dated July 2016, revealed the facility orders for medication and treatments will be consistent with principles of safe and effective order writing. Orders must be recorded on the physician's order sheet in the resident chart.

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	455551	A. Building B. Wing	07/01/2026

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interviews, the facility failed to conduct and document a comprehensive facility-wide assessment for the past year to determine what resources were necessary to care for its residents competently during day-to-day operations and review and update the assessment at least annually for 1 of 1 facility reviewed. The Facility Assessment had not been updated since January 2025. This failure could place residents at risk of their needs going unmet and result in a lack of services provided by the facility to competently care for all residents.The findings included: Record review of the Facility Assessment revealed the last documented review and update occurred in January 2025. During an interview on 06/30/26 at 1:59 PM, the AIT stated she had served in that role since July 2025. She stated she had not reviewed the Facility Assessment since assuming the position because she had not had time but stated it had been updated before the previous survey. The AIT stated it was her responsibility along with the ADM to update the Facility Assessment and acknowledged it should be reviewed and updated annually or whenever significant changes occurred. The AIT stated the only changes since the last update had been administrative leadership changes and indicated she would update the assessment that day with assistance from the Interim ADM. During an interview on 06/30/26 at 2:55 PM, the Interim ADM stated that she had been employed at the facility since February 2026. She stated she had not reviewed the Facility Assessment upon assuming her position and was unsure when it had last been updated. The Interim ADM stated she believed it was her responsibility to update the assessment annually or when changes occurred and thought it had already been updated during 2026. Record review of a facility policy titled Facility Assessment revised October 2018 revealed in part. A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. 9. The facility assessment is reviewed and updated annually, and as needed .