STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675478	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie House Living Center	1301 Mesa Dr 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161 Based on observation, interview and record review the facility failed to ensure residents were treated with respect and dignity and care for each resident in a manner and in an environment, that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 20 residents (Resident #45) reviewed for dignity issues. The facility failed to ensure Resident #45's catheter drainage bag was covered and urine in the bag was not visually exposed . This failure could place residents at risk of feeling uncomfortable and disrespected and could decrease residents' self-esteem and/or quality of life. Findings included: Record review of Resident #45's faced sheet, dated 11-13-2024, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #45 had diagnoses which included, but not limited to, acute kidney failure, neuromuscular dysfunction of bladder, benign prostatic hyperplasia with lower urinary tract symptoms . Record review of Resident #45's Annual MDS dated [DATE] reflected the following: Section C: Resident #45 had a BIMS of 03 out of 15, which indicated he was severely cognitively impaired. Section H; Resident #45 had an indwelling catheter. Record review of Resident #45's physician orders, dated 8-13-2024 , reflected provide catheter care every shift. During an observation on 11-13-2024 at 2:49 PM, revealed catheter care was performed by CNA F on Resident #45, Resident #45's catheter bag had no protective cover and was hanging from the right side of his bed in view of the hallway with his door open. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation from the hallway outside of Resident #45's room on 11-13-2024 at 3:26 PM revealed Resident #45 lying in bed asleep. Resident #45's catheter bag was observed hanging from the right side of his bed with no protective cover, there was a small amount of amber liquid was noted in the bag . During an interview on 11-13-2024 at 3:15 PM, LVN D stated all catheter bags should be covered at all times. LVN D stated that a possible negative outcome for not having a bag covered would be a resident could be embarrassed if other residents saw their urine. During an interview on 11-13-2024 at 3:20 PM, CNA F stated all catheter bags should be covered at all times. CNA F stated a possible negative outcome for not having a bag covered would be a dignity issues if other people saw the uncovered bag. During an interview on 11-13-2024 at 3:58 PM, RN E stated he addressed this issue before with his staff and all staff were responsible for ensuring catheter bags were covered because it was a dignity issue. Record review of the facility's provided policy titled, Resident Rights, dated 02-20-2021, reflected the following: .The resident has a right to be treated with respect and dignity, .The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882 Based on observation, interview, and record review the facility failed to ensure residents had a right to ade a safe, clean, comfortable and homelike environment, which included but not limited to receiving treatment and supports for daily living safety for 1 of 1 resident refrigerators reviewed for resident environment . 1. The facility failed to ensure expired and rotten food was removed from residents refrigerator, located by the main nurses station. 2. The facility failed to ensure residents personal refrigerators maintained sanitary conditions. 3. The facility failed to ensure foods in residents personal refrigerators were labeled and dated. These failures could place residents at risk of contracting foodborne illness and not having their personal food items stored in a sanitary manner. Findings Included: An observation on [DATE] at 2:00 pm of the resident refrigerator located in the hallway by the main nurse's station revealed the following in the freezer: A package of taquitos, open to air, no label or date, ice crystals on the taquitos. A package of opened chicken strips, open to air. 10 frozen breakfast meals with an expiration date of [DATE]. 5 individual ice cream bars, not in original package, no label or date. 1 medium uncovered Sonic Styrofoam cup of a milkshake or ice cream type drink, had no label or date. An observation on [DATE] at 2:05 pm of the main refrigerator revealed the following: 2 plastic bags of salad, no label, with an expiration date of [DATE]. The lettuce was limp and appeared to be slimy. 2 half sandwiches in a resealable plastic bag, no label or date. The bread was soggy, and the sandwich filling was unidentifiable and appeared moldy. Several, small, clear, plastic to go containers of what appears to be tartar sauce, and other condiments had no label or date. Condiments appeared to be dried and crusted inside the cups. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 02:10 pm, CNA C stated she did not know who was responsible for keeping the refrigerator in order. She stated she had never been told to clean out the refrigerator. She stated that was the resident refrigerator and staff were not supposed to put any personal foods in the refrigerator. She stated she did not know whether any of the food were staff food or not. During an interview on [DATE] at 02:30 pm, the DM stated the nursing staff were responsible for cleaning and maintenance of the resident snack refrigerator. She stated the residents and staff did not tell her or the kitchen staff when foods were brought into the facility, so she and the kitchen employees never knew what was in the refrigerator. She stated the refrigerator was for resident foods and staff were supposed to use the refrigerator. She stated all foods should be labeled and dated as well as secured. She stated all expired foods should be thrown out and the nursing staff was responsible for maintaining the refrigerator. She stated a possible negative outcome of the refrigerator containing rotting or expired food would be residents could be exposed to foodborne illnesses. She stated she was a contract worker for the facility and her supervisor, and the kitchen policies stated the nursing staff was responsible for maintenance of the resident refrigerator. During an interview on [DATE] at 02:35 pm, LVN D stated she did not know who was responsible for keeping the refrigerator in order. She stated she had never been told to clean out the refrigerator. She stated that was the resident refrigerator and staff were not supposed to use the refrigerator for personal food. During an interview on [DATE] at 3:30 pm, RN E stated he was not sure who was responsible for maintenance of the resident refrigerator and had never been told to maintain the refrigerator. He stated he had been told staff were not to put any personal food items in the refrigerator and did not know if there were staff personal food items in the refrigerator. He stated all foods in the refrigerator should be labeled and dated and expired foods should be thrown out. He stated the consequences of having expired foods and unlabeled, undated foods would be residents could be exposed to foodborne illnesses. During an interview on [DATE] at 3:42 pm, ADON B stated she was not sure who was responsible for maintenance of the resident refrigerator and thought it might be housekeeping or dietary services. She stated staff were not to put any personal food items in the refrigerator and did not know if there were staff personal food items in the refrigerator. She stated all foods in the refrigerator should be labeled and dated and expired foods should be thrown out. She stated the consequences of having expired foods and unlabeled, undated foods would be residents could be exposed to foodborne illnesses. Record review of the facility's policy titled Food From Outside Sources and dated [DATE] revealed the following: The task of keeping personal foods stored in a safe and sanitary manner will be the responsibility of the facility staff. Sealed containers must be used. Foods brought in by families and visitors may not enter the food service department, may not be stored in the kitchen, and may not be served by food service personnel. Residents and guests will be encouraged to date restaurant and homemade items and to consume or discard within 7 days. Record review of facility's policy titled Frozen and Refrigerated Foods Storage dated [DATE] revealed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Proper labeling of cooked food includes the date placed in the refrigerator and an expiration or use by date . The use by date is 7 days from when the product was opened unless there is a manufacturers use by date 11. All refrigerator and frozen items will be labeled and dated. 14. On a daily basis the Charge Nurse will check unit refrigerators that are used to store any resident foods and /or supplements: and check the temperature is 41 degrees or below, check to make sure all opened foods have use by dates and are properly covered, all items past use by date are discarded and refrigerators are clean.

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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** 48161 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and described the services that were to be furnished to attain or maintained the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 20 residents (Residents #69 and #12) reviewed for comprehensive care plans. 1. The facility failed to ensure Resident # 69's comprehensive care plan addressed the resident's need for a scoop mattress. 2. The facility failed to ensure Resident #12's comprehensive care plan addressed the resident's need for a fall mat. These failures could place residents at risk for not receiving the appropriate care and services needed to maintain optimal health. Finding included: 1. Record review of Resident #69's face sheet, dated 11/13/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #69 had diagnoses which included but not limited to lack of coordination, sequelae of other cerebrovascular disease(paralysis-partial), and seizures. Record review of Resident #69's quarterly MDS Assessment, dated 10/02/2024, reflected Resident #69 had a BIMS of 13 out 15, which indicated he was cognitively intact. Resident #69 required moderate assistance with lying to sitting on the side of the bed and chair to bed transfer. Record review of Resident #69's care plan, dated 10/08/2024, Resident #69 was a risk for falls due to gait/balance problems with interventions of the bed being in the low position and call light in reach, there was no documentation of using a scoop bed relating to Resident #69 risk of falling. No documentation throughout the care plan related to the utilization of a scoop mattress . Record review of Resident #69's Fall Risk Assessment, dated 10/13/2024, reflected Resident #69 was a moderate risk for falling due to decreased muscle coordination. During an observation on 11/12/2024 at 9:30 AM, Resident #69 was lying in his bed asleep, his bed was observed to be contoured with raised edges. During an observation on 11/13/2024 at 8:26 AM, Resident #69 was lying in his bed asleep, his bed was observed to be contoured with raised edges. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview/observation on 11/13/2024 at 2:23 PM revealed, Resident #69 was sitting in his motorized chair, Resident #69 had no concerns about his bed. Observation of the bed revealed it was contoured with raised edges . 2. Record review of Resident #12's face sheet, dated 11/13/2024, reflected an [AGE] year-old female who was admitted to the facility 10/01/2021. Resident #12 had diagnoses which included but not limited to unspecified fall, unspecified sequelae of cerebrovascular disease (paralysis-partial) and muscle weakness. Record review of Resident #12's quarterly MDS assessment, dated 10/30/2024, reflected Resident #12's BIMS was 02 out of 15, which indicated she had severe impaired cognition. Record review of Resident #12's care plan, dated 11/06/2024, reflected Resident #12 was at risk for falls related to cognitive impairment, gait/balance problems with interventions of bed being in the low position and call light in reach, no documentation of using a fall mat relating to Resident #12 risk of falling. There was no documentation throughout the care plan related to the utilization of the fall mat. Record review of Resident #12's Fall Risk Assessment, dated 10/08/2024 , reflected Resident #12 was a moderate risk for falling due to loss of balance . During an observation on 11/13/2024 at 10:00 AM, revealed Resident #12 was asleep in her bed, with a fall mat beside the bed. During an interview and observation on 11/13/2024 at 2:31 PM revealed, Resident #12 was in her bed, the fall mat was beside the bed. Resident #12 stated she felt safe with the fall mat near her bed. During an interview on 11/13/2024 at 3:25 PM, LVN G stated a possible negative outcome for not having accurate care plans would be the lack of care for residents. During an interview on 11/13/2024 at 3:45 PM with ADON B revealed the interventions for falls included scoop mattresses and fall mats should be in each resident's care plan. ADON B stated she was responsible for ensuring interventions were documented in the care plans. ADON B said a possible negative outcome for not having interventions in the care plan would be a lack of care of residents. During an interview on 11/14/2024 at 9:01 AM with the ADM, the ADM stated nurses were responsible for ensuring care plans were updated. The ADM stated a possible negative outcome for not having interventions in care plans would be the accuracy of care and care could be missed . Record review of the Care Plans and Care Area Assessments policy, dated 05/06/2024, reflected the following: Care Plan Updates: .The IDT will review the care plans Annually, quarterly, and as needed to ensure all goals and approaches are appropriate . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.As acute problems or changes to intervention or goals are identified, an appropriate care plan will be developed or modified by a nursing staff member . Record review of Fall Management System, dated 01/03/2017, reflected the following: It is the policy of this facility that each resident will be assessed to determine his/her risk for fall and a; plan of care implemented based on the resident's assessed needs .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice for 2 (Resident #66 and Resident #68) of 5 residents reviewed for respiratory care. 1. The facility failed to obtain orders for Resident #66's oxygen therapy. 2. The facility failed to ensure Resident #68's order for oxygen included the rate (lpm) at which she was to receive oxygen. These failures could affect all residents on oxygen therapy by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, and exacerbation of their condition. Findings include: 1. Record review of Resident #66's face sheet printed 11/12/2024 revealed a [AGE] year-old female resident admitted to the facility originally on 9/27/2023 and readmitted on [DATE] with diagnoses to include acute respiratory failure (sudden failure of lungs to deliver oxygen to the body) with hypoxia (low level of oxygen in your body tissue), congestive heart failure (a chronic condition in which the heart dose not pump blood as well as it should), hypertension(a condition in which the force of the blood against the artery walls is too high), major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and cognitive communication deficit(difficulty with thinking and how someone uses language). Record review of Resident #66's clinical record revealed her last MDS was a quarterly completed 11/1/2024 listing her with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring partial/moderate assistance with most of her activities of daily living. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #66 was marked as having oxygen While a Resident. Record review of Resident #66's Physician Orders with active orders for Schedule for [DATE] revealed no orders for oxygen therapy. Record review of Resident #66's clinical record revealed a care plan with the admitted [DATE], with the following care plan: Focus: o Oxygen: Resident uses oxygen therapy routinely or as needed and is at risk for ineffective gas exchange. Date Initiated: 09/27/2023. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 03/19/2024 Goal: o Resident will have no signs or symptoms of hypoxia through the next review dates. Date Initiated: 09/27/2023. Target Date: 01/22/2025 Intervention: o Administer oxygen therapy per physician's orders. Date Initiated: 09/27/2023. During an observation on 11/12/24 at 09:35 AM Resident #66 was in her bed sleeping with her oxygen on via nasal canula at 3.5L/min. During an observation and interview on 11/13/24 at 01:37 PM Resident #66 was in her room sitting in her chair with her family member present. Resident #66 was not wearing her oxygen but verified that she used oxygen and that she wore it only at night or when she was sleeping. During an interview on 11/14/24 at 08:20 AM LVN H (the nurse responsible for Resident #66 this shift) verified that Resident #66 was supposed to be on oxygen at night, that she (LVN H) had checked Resident #66's O2 sat this morning at 94% but that she did not verify if Resident #66 was wearing her Oxygen. LVN H reviewed Resident #66's chart and verified that Resident #66 did not have any orders for Oxygen therapy. LVN H then entered Resident #66's room and verified that Resident #66 was wearing Oxygen at 3.5L via a NC. LVN H reported that Resident #66 should have orders for her Oxygen therapy due to oxygen was considered a medication and reported that she would call the physician immediately and get an order. LVN H reported that administering the medication without an order should be a medication error and that it would be a treatment issue for the resident and that it could affect the resident's care. During an interview on 11/14/24 at 08:25 AM when questioned if Resident #66 had orders for her oxygen therapy the DON asked ADON B to check the residents electronic chart. ADON B checked the electronic chart and verified there were no orders for the oxygen therapy. ADON B then called the provider for orders. The DON reported that Resident #66 not having orders for her oxygen therapy was an issue and that it affected quality of care in that the resident would not be getting their medication therapy correctly which definitely could affect the resident negatively. 2. Record review of Resident #68's admission record dated 11/13/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, emphysema (a lung disease which results in shortness of breath), chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue), and obstructive sleep apnea (a sleep disorder that causes repeated breathing interruptions during sleep). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #68's quarterly MDS completed on 11/05/24 revealed the following: Section C: Resident #68 had a BIMS of 15 which indicated intact cognition. Section O: Resident #68 was not coded as receiving oxygen therapy. Record review of Resident #68's care plan completed on 09/04/24 revealed oxygen therapy was to be provided as ordered by the physician related to Resident #68's diagnoses of emphysema, chronic obstructive pulmonary disease, and sleep apnea. Record review of Resident #68's active order summary dated 11/13/24 revealed the following orders related to O2: An order with order date of 10/21/24 to Change O2 tubing and humidifier bottle. every night shift every Sun [Sunday] Ensure that tubing is dated when changed. An order with order date of 10/21/24 to Inspect external O2 filter weekly (if present). Clean/change if needed. every night shift every Sun for O2 use. An order with order date of 10/21/24 to Monitor O2 saturation. Apply PRN O2 if SpO2 falls below 90%. Notify the physician if SpO2 falls below 85%. every shift. The active order summary revealed no mention of lpm. Record review of Resident #68's O2 sats from 10/21/24 and 11/12/24 revealed her oxygen was checked 47 times. Of those 47 times she was receiving O2 via NC 38 times. The other 9 times she was breathing room air. Of those 9 times Resident #68's O2 sats were 90% or lower 3 times. Record review of Resident #68's MAR for October and November 2024 revealed the same orders listed above regarding O2 and made no mention of lpm. During an observation on 11/13/24 at 08:22 AM Resident #68 was lying in her bed with her eyes closed receiving O2 via NC at 4.25 lpm. During an observation on 11/13/24 at 01:42 PM Resident #68 was lying in her bed on her left side receiving O2 via NC at 4.25 lpm. On 11/13/24 at 02:23 PM an unsuccessful attempt was made to contact/interview Resident #68's physician who wrote the order for her PRN O2. During an observation on 11/13/24 at 03:12 PM Resident #68 was lying in bed on her right side receiving O2 via NC at 4.25 lpm. During an interview on 11/13/24 at 03:28 PM PC stated an order for oxygen should contain a rate (lpm) because we have to know how fast to run it because it will be different for each resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 03:37 PM DON stated nurses were responsible for setting lpms on O2 concentrators for residents receiving oxygen. She stated nurses would know what lpm to set the O2 to by referring to physician's orders. DON was asked for a copy of the facility's standing orders for O2. She stated a resident's quality of care could be negatively impacted by receiving O2 without orders specifying the lpms. She stated a resident could become hypoxic. During an interview on 11/13/24 at 03:38 AM ADON A stated nurses were responsible for setting O2 levels on the O2 concentrators. She stated nurses would refer to physician's orders to find O2 levels. She stated a possible negative outcome of orders that did not specify the level for O2 was a resident might not receive enough O2 which could lead to lethargy or confusion. ADON A stated a possible negative outcome for a resident with COPD receiving oxygen without the level specified by the physician's order was the resident's CO2 levels could increase which would affect everything. During an observation and interview on 11/13/24 at 03:40 PM LVN D stated nurses were responsible for setting O2 levels on O2 concentrators. She stated she would look at the physician's order to determine how high to set the O2 level. LVN D attempted to look at the O2 order for Resident #68 to determine the level for Resident #68's O2. She spent approximately 2 minutes looking at her computer screen and then stated, You are right, I don't see them (lpms) here. She stated most residents start out on 2 lpm of O2 but the order still has to be in there. LVN D stated if she came across an order with no lpms she would start the O2 at 2 lpm and then find out from the physician. During an interview on 11/13/24 at 04:00 PM RN E stated nurses were responsible for setting O2 levels on O2 concentrators. He stated nurses would look at physician's orders to determine the level of lpms. He stated if a resident with COPD was receiving O2 without specified lpms from the physician, It could knock out their respiratory drive. You don't want to see (someone with COPD receiving O2 at rates of) more than a couple of liters. Record review of the facility provided policy titled Oxygen Administration dated 9/12/2014, revealed the following: Procedure: 1. Verify the Physicians Order. 6. Set flow rate Record review of the facility provided policy titled Medication-Treatment Administration and Documentation Guidelines dated 1/9/2014, revealed the following: Process: 2. Verify administration accuracy by checking the medication with the MAR three (3) times. 4. Administer the mediation according to the physician order. 12. Review each MAR and TAR after each medication and treatment administration is completed and prior to the end of the shift to validate documentation is completed and supports services provided according to physician orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675478	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie House Living Center	1301 Mesa Dr 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14. Complete a Medication Error Report for medication administration discrepancies.