STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676079	A. Building B. Wing	11/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Nursing Care Center	1100 W Ave J Muleshoe, TX 79347

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services that assure the accurate dispensing and administering of all drugs for two (Resident #1, #2) of five residents reviewed for pharmacy services. Resident #1 who was nonverbal and bedridden and dependent on staff for all care needs, tested positive for barbiturates on 11/14/2025. The medical record did not contain documentation of a current barbiturate prescription. Resident #2's was prescribed Primidone 50mg, a medication that metabolizes in the body as a barbiturate was missed per the MAR on 11/08/2025 and 11/09/2025. These failures could place residents in the facility at risk of adverse drug reactions, untreated or uncontrolled medical conditions and a decline in health status.Record review of Resident #1's face sheet dated 11/15/2025 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but not limited to Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), unspecified, Dementia with other behavioral disturbances(impaired judgement with agitation), dysphagia, oropharyngeal phase (impaired ability to safely swallow foods or liquids) and muscle weakness.Record review of Resident #1's quarterly MDS dated [DATE] listed her with a BIMS of 00 of 15 indicating she was severely cognitively impaired. The MDS further reflected that she required total assistance from staff for all activities of daily living. Record review of Resident #1's care plan with date of 11/6/2025 revealed Resident #1 had an ADL self-care deficit due to weakness, loss of muscle mass, movement and impaired cognition with interventions require extensive assistance from staff.Record review of Resident #1's active and discontinued physician orders revealed she did not have any prescribed medications that would result in a positive test for barbiturates. Record review of Resident #1's progress notes revealed on 11/13/2025 resident went to emergency room due to not feeling well on the afternoon of 11/13/2025.Record review of Resident #1's hospital notes for 11/13/2025 revealed resident had a UTI and lab test resulting in a positive lab test for barbiturates. Record review of Resident #2's Face Sheet dated 11/15/2025 revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses that included but not limited to Bell's Palsy (paralysis of muscles on one side of face), Parkison's disease with dyskinesia (neurological disorder that affects movement), essential tremor (uncontrollable movement), muscle weakness.Record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 had a BIMS of 15 out of 15 indication cognition was intact and his functionality was independent with most of his daily activities.Record review of Resident #2's care plan dated 11/09/2025 revealed Resident #2 is a risk for falls due to tremors related to Parkinson's Disease.Record review of Resident #2's active physician orders revealed he takes Primidone Oral Tablet 50 mg. with orders to Give 1.5 tablet by mouth at bedtime related to Parkinson's disease with dyskinesia order dated 07/07/2025.Record review of Resident #2's MAR for November 2025 revealed resident did not receive his Primidone Oral Tablet 50 mg on 11/08/2025 or 11/09/2025.In an interview and observation on 11/15/2025 beginning at 7:37 AM, LVN C said she worked 11/13/2025. LVN C said Resident #1 was observed doing her normal behaviors on 11/13/2025 but in the afternoon was observed not doing her normal behavior moving her arms and legs when engaged with staff so the DON was informed, and she was evaluated by the DON and sent to the ER. LVN C said she was questioned about giving Resident #1 the Primidone but stated she checks three times between the medication and resident before giving the medication. LVN C said a possible negative outcome for giving a resident medication that did not belong to them could be that they could become sick. On observation of the med cart, revealed Resident #1's medication behind her card and Resident #2's medication behind his card, including the Primidone. The medications belonging to each resident were behind the card that displayed their name.In an interview on 11/15/2025 at 9:30 AM, The DON stated she assessed Resident #1 on 11/13/2025 during afternoon rounds when staff informed her that Resident #1 was not moving her arms and legs as she normally did, since Resident #1 was nonverbal that was how staff identified the concern. The DON called the physician, and he ordered her to send Resident #1 to the hospital for evaluation. The DON stated she returned on 11/14/2025 and the discharge paperwork from the hospital revealed she had a UTI and was prescribed an antibiotic but that she also tested positive for barbiturates. The DON said there were no barbiturates in the facility and did not know how she could test positive for such so she called the pharmacist, and the pharmacist said the drug Primidone metabolizes as a barbiturate and would come up in lab work as a barbiturate. The DON said the only resident in the facility that received Primidone was