| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status: that is, a deterioration in mental health, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 5 residents (Resident #2) for a change of condition. The DON failed to immediately consult with Resident #2's physician when she was found in her bed unresponsive but was still breathing on 1/22/26 at approximately 4:30 a.m. At approximately 11:10 a.m., Resident #2 had seizure like activity and was sent to the hospital. Resident #2 was diagnosed with a non-traumatic brain hemorrhage and subsequently died. An IJ was identified on 2/5/26. The IJ template was provided to the facility on 2/5/26 at 4:00 p.m. While the IJ was removed on 2/6/26 at 1:57 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on contacting the physician when a resident has a change of condition. This facility failure placed all residents at risk of serious harm or injury due to delaying possible life saving treatment and/or intervention, possible hospitalization or death.Findings Included: Record review of Resident #2's face sheet revealed Resident #2 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had the following diagnoses: dementia without behavioral disturbances (presently with signs and symptoms of dementia but lack behavioral symptoms), chronic kidney disease - Stage 4 (irreversible loss of kidney function often causing waste to build up in the blood), Atrial Fibrillation (irregular and often rapid heart rate causing the heart's upper chamber to quiver instead of contracting properly), Depressive episodes (persistent low mood, loss of interest, severe fatigue and difficulty concentrating), personal history of pulmonary embolism (sudden blockage in a lung artery), trigeminal neuralgia (chronic pain condition causing severe, sudden, electric shock-like facial pain), specified diseases of pancreas (diabetes), acute pain due to trauma, Fracture of lower end of right femur, urinary tract infection, ESBL resistance, acute upper respiratory infection, hypocalcemia (low calcium levels in the blood), cognitive communication deficit, muscle weakness, lack of coordination, Chronic Obstructive Pulmonary Disease (progressive, inflammatory lung disease), fracture of shaft of right tibia (break in lower leg bone), facture of shaft of right fibula (break in lower leg bone), hypertensive emergency (sudden, severe increase in blood pressure), ill-defined heart disease, chronic respiratory failure with hypoxia (respiratory failure with inadequate oxygen at the cellular level), obesity, fracture of lower end of left femur (break in leg), long term use of anticoagulants, heart failure, macular degeneration (a progressive deterioration of the maculae of the retina and choroid of the eye), hypertension (high blood pressure), cerebrovascular disease (heart disease), spinal stenosis (herniated disks and bone spurs on spine) and retention of urine. Resident #2 was the only person listed as the responsible party. Resident #2 was a DNR.<br><br>(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 |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #2's annual MDS assessment, dated 10/14/25, revealed the resident scored 12 of 15 on a BIMS for cognitive awareness which indicated she had moderately impaired cognition. Resident #2 had impairment of both lower extremities, used a wheelchair, substantial assistance with toileting, showering, dressing, personal hygiene, totally dependent on 2 staff for transfers, incontinent, frequent moderate pain, no falls, prescribed an antidepressant, anticoagulant, opioid, antiplatelet and an anticonvulsant. Record review of Resident #2's care plan, last reviewed 7/18/25, revealed Resident #2 was care-planned for:*Refuses to get out of bed for meals despite continuous education on risk of aspiration (when food or liquid is breathed into the airways and lungs instead of being swallowed). Verbalizes understanding of risk of aspiration but states she knows her rights and has the right to lay in bed and eat if she wishes. Intervention: Continue to educate of the risk for aspiration, continue to encourage Resident #2 to attend meals in the dining room or to set up in chair or edge of bed for meals. Encourage Resident #2 to sit upright for meals, leave call light in reach and check on her frequently throughout meal. Ensure Resident #2 is sitting up in bed during meals, or positioned correctly in bed prior to eating, monitor skin for breakdown. *a seizure disorder related to resection of meningioma (surgical treatment for removing noncancerous tumors from the brain) in 1989. Interventions: Give Dilantin as ordered by doctor. Monitor labs and report any sub therapeutic or toxic results to physician. Dilantin level every 6 months. Post seizure treatment: turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure, take vital signs and neuro check, monitor for aphasia (impairment of ability to speak, understand, read and write), headache, altered level of consciousness, paralysis, weakness or pupillary changes. Seizure documentation: location of seizure activity, type of seizure activity, duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Seizure Precautions: Do not leave alone during a seizure. Protect from injury, if out of bed, help to the floor to prevent injury. Remove or loosen tight clothing. Don't attempt to restrain during a seizure as this could make the convulsions more severe. Protect my privacy. *An alteration of hematological status (overall health of an individual's blood, bone marrow and related components) related to use of Eliquis and NSAID aspirin. Interventions: administer ferrous sulfate and vitamin C as ordered. CBC blood test as ordered every 6 months, Give Eliquis as ordered, monitor for side effects, monitor for any signs or symptoms of bleeding, hard, raised, elevated bruising, hematuria, hematemesis, bleeding gums, bloody stools, notify doctor immediately of any abnormal findings. Monitor/document/report to physician as needed the following signs and symptoms of anemia, pallor (loss of color from skin), fatigue, dizziness, syncope, headache, palpitations, weakness, feeling of cold, low blood count, shortness of breath on exertion, sore tongue, chest pain, tinnitus (ringing in the ears), changes in mental status. *Multiple cardiac issues: CAD, hyperlipidemia, atrial Fibrillation, CHF, anemia and HTN. Interventions: Administer oxygen as ordered, continuous oxygen via nasal cannula at 2 liters, ensure medications are given for treatments for conditions, monitor, document and report to physician any signs or symptoms of complications related to A-fib such as chest pain or pressure especially with activity, rapid heart rate, signs or symptoms of poor perfusion, shortness of breath, signs or symptoms of cerebral vascular accident (stroke). Obtain/monitor/report to physician lab work as ordered every 6 months, weights as ordered and as needed. *Altered respiratory status related to sleep apnea and chronic respiratory failure with hypoxia and had an order for CPAP at night but constantly refused to wear it and therefore the order for CPAP was discontinued but uses continuous O2 throughout the day. Interventions: administer inhaler as ordered, encourage resident to use her oxygen at bedtime, keep head of bed elevated. Monitor for signs and symptoms of respiratory distress and report to<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | physician - increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis (soaking in a cold sweat not related to heat or exercise), headaches, lethargy, confusion, cough, pleuritic pain (painful inflammation of the lining of the lungs), accessory muscle usage, skin color changes to blue/grey. *Urinary incontinence and have a history of chronic urinary tract infections. Interventions: check and change brief at least every 2 - 3 hours for incontinence, wash, rinse and dry soiled areas, encourage adequate fluid intake. Moisture barrier cream/ointment to peri-area after each incontinent episode, monitor intake and output, obtain and monitor lab/diagnostic work as ordered, urinalysis with culture if indicated every month, report results to physician and follow up as indicted. May straight cath as needed. When/If urinary tract infection diagnosed - give antibiotic therapy as ordered. Monitor for side effects. *Renal insufficiency (Stage 4) and am at risk of fluid volume overload due to the decreased renal filtration rate. Interventions: assist with ADLs, watch for shortness of breath and match level of assistance to residents' current energy level. Auscultate (listen to) heart and lung sounds, notify physician of any noted abnormal findings. Elevate feet to help prevent dependent edema (swelling). Monitor and report changes in mental status, lethargy, tiredness, fatigue, tremors or confusion *Impaired cognitive function related to dementia. Interventions: identify yourself at each interaction, face resident when speaking and make eye contact. Reduce any distractions, provide resident with necessary cues - stop and return if agitated, provide a program of activities that accommodate resident's abilities *Impaired visual function related to macular degeneration (progressive eye disease causing central vision loss). Interventions: read and explain any written communication to resident. Resident does not use glasses and does not want them, states her vision cannot be corrected. Report to physician any signs or eye problems. *Potential for communication problems related to hearing deficit. Interventions: be conscious of my age-related hearing loss. Usually have television on very loud so she can hear it. She has headphones but doesn't like to use them. Face to face communication. *Chronic pain. Interventions: Administer medications for pain as ordered. Monitor for effectiveness and report to physician if needed. If pain is present, monitor and record characteristics - sharp or burning - severity from 0 - 10 on pain scale. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decreased range of motion, withdrawal or resistance to care. Record review of Resident #2's nurses notes revealed the following:1/22/26 at 6:56 a.m. documented by the DON - Resident continue follow-up for Nitrofurantoin (antibiotic) for UTI. Nurse was called to the resident's room by CNAs this morning due to resident being unresponsive. Nurse could not get the resident to respond. Vitals signs were WNL, and no distress was noted. Breathing was not labored, and the resident appeared to be resting comfortably with no distress. Told CNAs to increase monitoring and let me know of any changes. 1/22/26 at 7:02 a.m. - documented by the DON - called back to the resident's room at 4:40 a.m. due to blood in resident's mouth. After cleaning, it was apparent that the resident had bitten her bottom lip. Lip and mouth were cleansed, and no further bleeding was noted. Resident #2 still sleeping very soundly and no distress is noted.1/22/26 at 2:47 p.m. - documented by LVN A - At approximately 11:10 a.m. during peri care, the resident began having seizure activity that lasted approximately 30 seconds. Following seizure, Resident #2 was noted to be unresponsive with shallow, labored respirations. Did not respond to tactile (the sense of touch) or painful stimuli. Vital signs - blood pressure 163/89, temperature 97.3 degrees Fahrenheit, respirations 79, pulse 20, oxygen saturation 93% on two liters per minute via nasal cannula. EMS was called for transport to the ER at 11:15 a.m. and arrived at facility at 11:22 a.m. The resident left facility via stretcher at 11:35 a.m. to be transported to hospital via ambulance. The doctor and Administration were notified. 1/23/26 at 10:52 a.m. - documented<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | by the DON - the DON got report from the hospital the resident passed away in the hospital and was pronounced dead at 5:05 a.m. on 1/23/26. Record review of Hospital Records for Resident #2 documented the following:*A CT scan, dated 1/22/26 at 11:28 a.m., documented a large area of parenchymal hemorrhage (life-threatening type of stroke involving bleeding directly into the brain) within the left temporal frontal lobe (critical area for language comprehension and verbal memory). MRI would be recommended if there is concern for acute stroke.*A chest x-ray revealed slight basilar pneumonia (mild infection affecting the lower bases of both lungs).*1/22/26 at 11:58 a.m. - ED Provider Note: This [AGE] year-old female presents via EMS after seizure activity. Patient witnessed having a grand-mal type seizure. Patient stopped seizing but has yet to regain consciousness. Patient had a blood pressure of 209/119 prior to arrival per EMS. Patient is noted to have Cheyne-Stokes type respirations (dangerous, abnormal breathing pattern characterized by a cycle of shallow breaths that deepen, then shrink, and stop entirely, often lasting 45 seconds to 3 minutes) and is minimally responsive to verbal or painful stimuli.*1/22/26 at 12:17 p.m. - ED Provider Note: Called a larger hospital and spoke with staff on patient logistics line. Spoke with neurosurgery at the hospital after determining that the patient is a DNR/DNI. Neurosurgery agrees with keeping the patient here and providing comfort measures.*Death Summary Report dated 1/23/26 at 5:37 a.m. documented this [AGE] year-old female was admitted to in-patient for comfort care measures after she was found to have a large hemorrhagic stroke to the left side of her brain. Patient was noted to be minimally arousable to painful stimuli. Patient passed away at 5:09 a.m. The patient is DNI/DNR. Physical Exam: General: UnresponsiveEyes: Pupils are unreactiveHeart: No heart tones auscultatedProblems treated this visit: Nontraumatic intracerebral hemorrhage, intraventricular, convulsion disorder. During a telephone interview on 1/29/26 at 10:50 a.m., the DON stated she was working the night shift that night (1/22/26) and the girls (CNAs) were making their last rounds. The DON stated the CNAs called her down to Resident #2's room and she did not notice the resident in any distress. The DON stated Resident #2 seemed like she was sleeping soundly, she cracked her eyes a bit and she just seemed sleepy. The DON stated Resident #2 had been on an antibiotic and she thought Resident #2 might be going septic (severe life-threatening immune response to infection), but she was not sure. The DON stated Resident #2 had blood around her mouth and she cleaned it up and she could see where Resident #2 had bitten her lip. The DON stated she told the day shift to monitor her closely and her vitals were normal, but she was still not responsive. The DON stated the first report she received from the hospital was that Resident #2 had a hemorrhagic stroke (ruptured blood vessel in the brain) because she had bleeding in the brain. The DON stated Resident #2 passed away at the hospital maybe 48 hours after she was sent to the hospital. The DON stated she probably should have called the doctor, as it was 4:00 a.m. in the morning, and she was not thinking too clearly. The DON stated Resident #2 did not have any family, but she did have a family member that was in prison. The DON stated she did not think it was anything too serious with Resident #2 because she was not in distress, she had good color, her vitals were good, and her pupils were equal and reactive. The DON stated she was more concerned that Resident #2 bit her lip. The DON stated Resident #2 was obese and did not want to get out of bed. During a telephone interview on 1/29/26 at 1:22 p.m., LVN A stated she was taking care of Resident #2 the day she was sent to the hospital. LVN A stated she was told in report that Resident #2 had a bad night. LVN A stated that morning, she checked Resident #2's vitals when she came on duty at 6:00 a.m. and they were fine. LVN A stated after she got Resident #2's vital signs, she was more alert. LVN A stated she checked on Resident #2 later that morning and she was not as alert as she was and looked a little worrisome. LVN A stated she told the CNAs to get her ready to send out to the hospital. LVN A stated she was<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | getting Resident #2's paperwork together and the CNAs came and got her because Resident #2 was having some seizure like activity. LVN A stated EMS was immediately called and Resident #2 was sent out to the hospital. LVN A stated she was off for a few days and when she came back to work, she was told Resident #2 had passed away a day or two after being sent to the hospital. During a follow-up interview on 2/5/26 at 10:15 a.m., the DON stated she was working the floor on the night shift on 1/22/26. The DON stated around 4:30 a.m., the CNAs asked her to go to Resident #2's room because they felt something was wrong. The DON stated Resident #2 was unresponsive but was still breathing without any distress. The DON stated Resident #2 was not acting right. The DON stated she did a sternal rub and Resident #2 opened her eyes slightly but other than that, there was no response when she was asked questions. The DON stated Resident #2's pupils were equal and reactive. The DON stated she told the CNAs to monitor Resident #2 closely and to let her know of any changes. The DON stated she did not call the doctor then because it was early in the morning, but she absolutely should have called the doctor. The DON stated about 20 minutes later; Resident #2 had some blood on the side of her mouth and had a little bit on the outside of her lip. The DON stated she cleaned up the blood and there was no further active bleeding. The DON stated she should have called the doctor then, but she did not. The DON stated she then gave report to LVN A and LVN B, told them that she thought Resident #2 was septic. The DON stated Resident #2's vitals were taken, and they were still normal at that time so the two LVNs thought they would monitor her. The DON stated she went home after that and went to bed. The DON stated she received a text later that day that they were sending Resident #2 to the hospital. The DON stated no formal education had been done about notifying doctors and family members of any changes the residents had but she had talked to the nurses about that. During an interview on 2/5/26 at 11:05 a.m., LVN B stated he came on shift on 1/22/26 at approximately 6:00 a.m. and Resident #2 was opening her eyes and was nodding her head and answered yes or no questions. LVN B stated later that morning, Resident #2 looked like she had taken a turn for the worse because she seemed less responsive. LVN B stated the doctor was called at that time to send Resident #2 to the hospital. LVN B stated the CNAs were cleaning Resident #2 up and she had seizure activity. LVN B stated when Resident #2 was sent out with EMS, she was unresponsive. LVN B stated that when there was a change of condition in a resident, he would call the doctor to let them know of the resident's condition. During an interview on 2/5/26 at 11:20 a.m., CNA C stated she was taking care of Resident #2 the day she went to the hospital. CNA C stated LVN B told her to start getting Resident #2 cleaned up because she was going to be sent to the hospital. CNA C stated Resident #2 had her eyes closed and she was unresponsive. CNA C stated she turned Resident #2, and she opened her eyes, and she reported that to LVN B. CNA C stated she had another CNA helping her with Resident #2 to get her dressed. CNA C stated that was when Resident #2 had a seizure which was right before EMS got to the facility to take her to the hospital. During an interview on 2/5/26 at 11:50 a.m., Resident #2's physician stated if a resident of his was found to be unresponsive but still breathing, but not talking, even after having a sternal rub, he would want to be notified of that change in condition. Resident #2's physician stated if a resident was unresponsive and had bitten her lip, he would want to be notified. Resident #2's physician stated of the resident had possibly bitten her lip, she could have had a seizure and needed to be sent to out to the hospital. Resident #2's physician stated if he had known that Resident #2 was unresponsive that morning, he would have had her sent out to the hospital right then. Record review of the facility's policy titled, Acute Condition Changes - Clinical Protocol revealed the following:Assessment and Recognition: The physician will help identify, individuals with a significant risk for having acute changes of condition during their stay, for example, an individual with an<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | indwelling urinary catheter who has had recurrent symptomatic urinary tract infections, or someone with unstable vital signs or recurrent pneumonia. In addition, the nurse shall assess and document/report the following baseline information.Vital signsNeurological statusLevel of consciousnessOnset, duration and severity.Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse.The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay, that may indicate instability or the risk of having additional complications, for example, acute bronchitis or gastrointestinal bleeding in someone with advanced COPD who is receiving corticosteroids after a prolonged, complicated, recent hospitalization.The physician will help identify medications and mediation combinations that are associated with adverse consequences that could cause significant changes in condition.The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less).The Nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. The nurse and physician will discuss and evaluate the situation.Cause IdentificationThe staff and physician will discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, mediation regimen and diagnostic test results.Treatment/ManagementThe physician will help identify and authorize appropriate treatments. This was determined to be an Immediate Jeopardy (IJ) on 2/5/26 at 4:00 p.m. The Administrator and DON were notified and were provided with the IJ Template on 2/5/26 at 4:00 p.m. via in person and email. The following Plan of Removal was submitted by the facility and accepted on 2/6/26 at 7:43 a.m.Plan of Removal Plan for F580On 2/5/26 at 4:00 p.m., an Immediate Jeopardy (IJ) was identified related to Tag F580. The facility took immediate action to remove the jeopardy and ensure resident health and safety.Immediate Actions Taken*In-services initiated immediately in relation to notifications of Quality of Care:-Identify changes-Report Immediately-Document thoroughly-Follow facility policy-All changes in conditions - not baseline, will be notified immediately to Administrator/DON/Medical director/Primary Care Physician.*All residents were assessed by nursing staff.Protection of all Residents*All residents were assessed for potential harm related to this IJ on 2/5/26.*Any identified concerns will be addressed immediately.Staff Education*On 2/5/26, the DON was in-serviced by the Corporate RN on Notification of Change in Condition.*Staff education was initiated regarding Notification of change in conditions on 2/5/26 and will be completed on 2/6/26. Any staff who cannot be in-serviced by 2/6/26 will be in-serviced before their next shift.*Education included - see attachment.*Attendance was documented.Monitoring to Ensure Ongoing Compliance*The facility-initiated monitoring beginning 2/5/26.*Monitoring includes reviewing daily 24-hour reports and conducting daily resident rounds.*The Administrator/DON/Designee will review findings daily (M-F) for 4 weeks, then 3 x weekly for one month and then 1 x weekly for 1 month.Date of Compliance: 2/6/26 Monitoring of the Plan of Removal included the following: During an interview on 2/6/26 at 10:30 a.m., the DON stated she had all the paperwork for the POR in a folder. The DON stated she had the 24-hour report for this morning, which was reviewed, and things were highlighted for the doctor to be notified. The DON stated that right after the medication passes in the morning, the nurses assess every resident daily Monday through Friday for 4 weeks, then 3 times a week for one month, then once a week for one month. The DON stated they had a base line in-service covering neurological assessments, and then 43 pages of what was included, and they were working on that in-service right now. The DON stated<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | the education was ongoing as not all staff were available but would be in-serviced before they were allowed to work. The DON stated she had a one-on-one directed education by the corporate representative which covered the following areas: changes in condition assessments which is required for traumatic events (fall, injury) and changes in resident's baseline assessment, DON doing daily rounds, including Glascow Coma Scale in assessments, notification of primary physician and emergency contact to determine plan of care, document findings of assessment and notification in medical record. Record Review on 2/6/26 at 10:43 a.m. of the daily assessment sheet which will be used daily to assess every resident in the facility revealed the nurses will check any physical, behavioral or neurological concerns observed for that day. All residents were assessed from 2/5/26 t0 2/6/26 by checking current vitals, any pain concerns, reviewed progress notes. The physician and family were notified timely of two falls with no injury. Record Review of the in-service sheets reflected all staff were trained on the Facility's Plan of Removal, Daily Nurse Assessment Sheet, Change in Condition, Neurological Assessment and Change in Condition, What is a Change of Condition, 24-Hour Summary Reports and Seven Components of Prevention and Detection. Included with the In-service sheets, there was a Directed Education for the DON regarding change in condition assessments which included: 1. Baseline assessments for each resident, 2. Use of nursing assessment with a change of condition, 3. Notification of primary physician and emergency contact to determine plan of care, and 4. Document findings of assessment and notification in medical record. Interviews on 2/6/26 starting at 11:05 a.m., were conducted with staff working in the facility. All staff stated they had all been in-serviced over when a resident had a change of condition and who to report it to, if the nurse seemed uninterested or did not pay attention, report it to the DON or the Administrator. All nurses knew about daily assessments on all residents that need to be completed, also conducting neurological and behavioral assessments to ensure the residents did not have a change of condition that needed to be reported to the charge nurse or DON, what a change on condition could be and to know each residents baseline and what to look for.Interviews conducted included the following staff:Administrator and DONCNA D, F, GLVN B, EHousekeeping HCOTA IBOM/CMA/CNA JThe following interviews were conducted by telephone of all staff working all shifts, included the following: RNs - M, N, P, TLVNs - V, AA, BB, CCCNAs - K, L, O, Q, R, S, U, W, X, Y, Z The Administrator was informed the Immediate Jeopardy was removed on 2/6/26 at 1:57 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, 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 1 of 5 residents (Resident #2) who were reviewed for quality of care. The facility failed to provide the care and services to Resident #2 when her physician was not contacted on 1/22/26 at approximately 4:30 a.m. when she was found in her bed unresponsive but still breathing. Because the physician was not contacted or included in Resident #2's change of condition, she did not receive the best care available. An IJ was identified on 2/5/26 at 4:00 p.m. While the IJ was removed on 2/6/26 at 1:57 p.m., the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. This failure 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: Record review of Resident #2's face sheet revealed Resident #2 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had the following diagnoses: dementia without behavioral disturbances (presently with signs and symptoms of dementia but lack behavioral symptoms), chronic kidney disease - Stage 4 (irreversible loss of kidney function often causing waste to build up in the blood), Atrial Fibrillation (irregular and often rapid heart rate causing the heart's upper chamber to quiver instead of contracting properly), Depressive episodes (persistent low mood, loss of interest, severe fatigue and difficulty concentrating), personal history of pulmonary embolism (sudden blockage in a lung artery), trigeminal neuralgia (chronic pain condition causing severe, sudden, electric shock-like facial pain), specified diseases of pancreas (diabetes), Fracture of lower end of right femur, cognitive communication deficit, Chronic Obstructive Pulmonary Disease (progressive, inflammatory lung disease), fracture of shaft of right tibia (break in lower leg bone), facture of shaft of right fibula (break in lower leg bone), hypertensive emergency (sudden, severe increase in blood pressure), chronic respiratory failure with hypoxia (respiratory failure with inadequate oxygen at the cellular level), obesity, fracture of lower end of left femur (break in leg), long term use of anticoagulants, macular degeneration (a progressive deterioration of the maculae of the retina and choroid of the eye), hypertension (high blood pressure), cerebrovascular disease (heart disease), spinal stenosis (herniated disks and bone spurs on spine). Resident #2 was the only person listed as the responsible party. Resident #2 was a DNR. Record review of Resident #2's annual MDS assessment, dated 10/14/25, documented the resident scored 12 of 15 on a BIMS for cognitive awareness which indicated moderately impaired cognition. Resident #2 had impairment of both lower extremities, used a wheelchair, substantial assistance with toileting, showering, dressing, personal hygiene, totally dependent on 2 staff for transfers, incontinent, frequent moderate pain, no falls, prescribed an antidepressant, anticoagulant, opioid, antiplatelet and an anticonvulsant. Record review of Resident #2's care plan, last reviewed 7/18/25, revealed Resident #2 was care-planned for:*Refuses to get out of bed for meals despite continuous education on risk of aspiration. Verbalizes understanding of risk of aspiration (when food or liquid is breathed into the airways and lungs instead of being swallowed) but states she knows her rights and has the right to lay in bed and eat if she wishes. Intervention: Continue to educate of the risk for aspiration, continue to encourage Resident #2 to attend meals in the dining room or to set up in chair or edge of bed for meals. Encourage Resident #2 to sit upright for meals, leave call light in reach and check on her frequently throughout meal. Ensure Resident #2 is sitting up in bed during meals, or positioned correctly in bed prior to eating, monitor skin for breakdown. *a seizure disorder related to<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | resection of meningioma (surgical treatment for removing noncancerous tumors from the brain) in 1989. Interventions: Give Dilantin as ordered by doctor. Monitor labs and report any sub therapeutic or toxic results to physician. Dilantin level every 6 months. Post seizure treatment: turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure, take vital signs and neuro check, monitor for aphasia (impairment of ability to speak, understand, read and write), headache, altered level of consciousness, paralysis, weakness or pupillary changes. Seizure documentation: location of seizure activity, type of seizure activity, duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Seizure Precautions: Do not leave alone during a seizure. Protect from injury, if out of bed, help to the floor to prevent injury. Remove or loosen tight clothing. Don't attempt to restrain during a seizure as this could make the convulsions more severe. Protect my privacy. *An alteration of hematological status (overall health of an individual's blood, bone marrow and related components) related to use of Eliquis and NSAID aspirin. Interventions: administer ferrous sulfate and vitamin C as ordered. CBC blood test as ordered every 6 months, Give Eliquis as ordered, monitor for side effects, monitor for any signs or symptoms of bleeding, hard, raised, elevated bruising, hematuria, hematemesis, bleeding gums, bloody stools, notify doctor immediately of any abnormal findings. Monitor/document/report to physician as needed the following signs and symptoms of anemia, pallor (loss of color from skin), fatigue, dizziness, syncope, headache, palpitations, weakness, feeling of cold, low blood count, shortness of breath on exertion, sore tongue, chest pain, tinnitus (ringing in ears), changes in mental status. *Multiple cardiac issues: CAD, hyperlipidemia, atrial Fibrillation, CHF, anemia and HTN. Interventions: Administer oxygen as ordered, continuous oxygen via nasal cannula at 2 liters, ensure medications are given for treatments for conditions, monitor, document and report to physician any signs or symptoms of complications related to A-fib such as chest pain or pressure especially with activity, rapid heart rate, signs or symptoms of poor perfusion, shortness of breath, signs or symptoms of cerebral vascular accident (stroke). Obtain/monitor/report to physician lab work as ordered every 6 months, weights as ordered and as needed. *Altered respiratory status related to sleep apnea and chronic respiratory failure with hypoxia and had an order for CPAP at night but constantly refused to wear it and therefore the order for CPAP was discontinued but uses continuous O2 throughout the day. Interventions: administer inhaler as ordered, encourage resident to use her oxygen at bedtime, keep head of bed elevated. Monitor for signs and symptoms of respiratory distress and report to physician - increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis (soaking in a cold sweat not related to heat or exercise), headaches, lethargy, confusion, cough, pleuritic pain (painful inflammation of the lining of the lungs), accessory muscle usage, skin color changes to blue/grey. Record review of Resident #2's nurses notes documented the following:1/22/26 at 6:56 a.m. - documented by the DON - Resident continue follow-up for Nitrofurantoin (antibiotic) for UTI. Nurse was called to the resident's room by CNAs this morning due to resident being unresponsive. Nurse could not get the resident to respond. Vitals signs were WNL, and no distress was noted. Breathing was not labored, and the resident appeared to be resting comfortably with no distress. Told CNAs to increase monitoring and let me know of any changes.1/22/26 at 7:02 a.m. - documented by the DON - called back to resident's room at 4:40 a.m. due to blood in resident's mouth. After cleaning, it was apparent that resident had bitten her bottom lip. Lip and mouth were cleansed, and no further bleeding was noted. Resident #2 still sleeping very soundly and no distress is noted. 1/22/26 at 2:47 p.m. - documented by LVN A - At approximately 11:10 a.m. during peri care, the resident began having seizure activity that lasted approximately 30 seconds. Following seizure, Resident #2 noted to be<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | unresponsive with shallow, labored respirations. Did not respond to tactile (the sense of touch) or painful stimuli. Vital signs - blood pressure 163/89, temperature 97.3 degrees Fahrenheit, respirations 79, pulse 20, oxygen saturation 93% on two liters per minute via nasal cannula. EMS called for transport to the ER at 11:15 a.m. and arrived at the facility at 11:22 a.m. The resident left facility via stretcher at 11:35 a.m. to be transported to hospital via ambulance. The doctor and Administration notified. 1/23/26 at 10:52 a.m. - documented by the DON - The DON got report from hospital that resident passed away in the hospital and was pronounced dead at 5:05 a.m. on 1/23/26. Record review of Hospital Records for Resident #2 documented the following:*A CT scan, dated 1/22/26 at 11:28 a.m., documented a large area of parenchymal hemorrhage (life-threatening type of stroke involving bleeding directly into the brain) within the left temporal frontal lobe (critical area for language comprehension and verbal memory). MRI would be recommended if there is concern for acute stroke.*A chest x-ray revealed slight basilar pneumonia (mild infection affecting the lower bases of both lungs).*1/22/26 at 11:58 a.m. - ED Provider Note: This [AGE] year-old female presents via EMS after seizure activity. Patient witnessed having a grand-mal type seizure. Patient stopped seizing but has yet to regain consciousness. Patient had a blood pressure of 209/119 prior to arrival per EMS. Patient is noted to have Cheyne-Stokes type respirations (dangerous, abnormal breathing pattern characterized by a cycle of shallow breaths that deepen, then shrink, and stop entirely, often lasting 4 seconds to 3 minutes) and is minimally responsive to verbal or painful stimuli.*1/22/26 at 12:17 p.m. - ED Provider Note: Called a larger hospital and spoke with staff on patient logistics line. Spoke with neurosurgery at the hospital after determining that the patient is a DNR/DNI. Neurosurgery agrees with keeping the patient here and providing comfort measures.*Death Summary Report dated 1/23/26 at 5:37 a.m. documented this [AGE] year-old female was admitted to in-patient for comfort care measures after she was found to have a large hemorrhagic stroke to the left side of her brain. Patient was noted to be minimally arousable to painful stimuli. Patient passed away at 5:09 a.m. The patient is DNI/DNR. Physical Exam: General: UnresponsiveEyes: Pupils are unreactiveHeart: No heart tones auscultatedProblems treated this visit: Nontraumatic intracerebral hemorrhage, intraventricular, convulsion disorder. During a telephone interview on 1/29/26 at 10:50 a.m., the DON stated she was working the night shift that night (1/22/26) and the girls (CNAs) were making their last rounds. The DON stated the CNAs called her down to Resident #2's room and she did not notice the resident in any distress. The DON stated Resident #2 seemed like she was sleeping soundly, she cracked her eyes a bit and she just seemed sleepy. The DON stated Resident #2 had blood around her mouth and she cleaned it up and she could see where Resident #2 had bitten her lip. The DON stated she told the day shift to monitor her closely and her vitals were normal, but she was still not responsive. The DON stated she probably should have called the doctor, as it was 4:00 a.m. in the morning, and she was not thinking too clearly. During a telephone interview on 1/29/26 at 1:22 p.m., LVN A stated she was taking care of Resident #2 the day she was sent to the hospital. LVN A stated she was told in report that Resident #2 had a bad night. LVN A stated that morning, she checked Resident #2's vitals when she came on duty and they were fine. LVN A stated after she got Resident #2's vital signs, she was more alert. LVN A stated she checked on Resident #2 later that morning and she was not as alert as she was and looked a little worrisome. LVN A stated she told the CNAs to get her ready to send out to the hospital. LVN A stated she was getting Resident #2's paperwork together and the CNAs came and got her because Resident #2 was having some seizure like activity. LVN A stated EMS was immediately called and Resident #2 was sent out to the hospital. During a follow-up interview on 2/5/26 at 10:15 a.m., the DON stated she was working the floor on the night shift on 1/22/26. The DON stated around 4:30 a.m., the CNAs<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | asked her to go to Resident #2's room because they felt something was wrong. The DON stated Resident #2 was unresponsive but was still breathing without any distress. The DON stated Resident #2 was not acting right. The DON stated she did a sternal rub and Resident #2 opened her eyes slightly but other than that, Resident #2 there was no response when she was asked questions. The DON stated she did not call the doctor then because it was early in the morning, but that absolutely should have told her to call the doctor. The DON stated about 20 minutes later; Resident #2 had some blood on the side of her mouth and had a little bit on the outside of her lip. The DON stated she should have called the doctor then, but she did not. The DON stated she then gave report to LVN A and LVN B, told them that she thought Resident #2 was septic. The DON stated Resident #2's vitals were taken, and they were still normal at that time so the two LVNs thought they would monitor her. The DON stated she went home after that and went to bed During an interview on 2/5/26 at 11:05 a.m., LVN B stated he came on shift on 1/22/26 and Resident #2 was opening her eyes and was nodding her head and answered yes or no questions. LVN B stated later that morning, Resident #2 looked like she had taken a turn for the worse because she seemed less responsive. LVN B stated the doctor was called at that time to send Resident #2 to the hospital. LVN B stated the CNAs were cleaning Resident #2 up and she had seizure activity. LVN B stated when Resident #2 was sent out with EMS, she was unresponsive. During an interview on 2/5/26 at 11:20 a.m., CNA C stated she was taking care of Resident #2 the day she went to the hospital. CNA C stated LVN B told her to start getting Resident #2 cleaned up because she was going to be sent to the hospital. CNA C stated Resident #2 had her eyes closed and she was unresponsive. CNA C stated she turned Resident #2, and she opened her eyes, and she reported that to LVN B. CNA C stated she had another CNA helping her with Resident #2 to get her dressed. CNA C stated that was when Resident #2 had a seizure which was right before EMS got to the facility to take her to the hospital. During an interview on 2/5/26 at 11:50 a.m., Resident #2's physician stated if a resident of his was found to be unresponsive but still breathing, but not talking, even after having a sternal rub, he would want to be notified of that change in condition. Resident #2's physician stated if a resident was unresponsive and had bitten her lip, he would want to be notified. Resident #2's physician stated of the resident had possibly bitten her lip, she could have had a seizure and needed to be sent to out to the hospital. Resident #2's physician stated if he had known that Resident #2 was unresponsive that morning, he would have had her sent out to the hospital right then. Record review of the facility's policy titled, Acute Condition Changes - Clinical Protocol revealed the following:Assessment and Recognition: The physician will help identify, individuals with a significant risk for having acute changes of condition during their stay, for example, an individual with an indwelling urinary catheter who has had recurrent symptomatic urinary tract infections, or someone with unstable vital signs or recurrent pneumonia. In addition, the nurse shall assess and document/report the following baseline information.Vital signsNeurological statusLevel of consciousnessOnset, duration and severity.Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse.The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay, that may indicate instability or the risk of having additional complications, for example, acute bronchitis or gastrointestinal bleeding in someone with advanced COPD who is receiving corticosteroids after a prolonged, complicated, recent hospitalization.The physician will help identify medications and mediation combinations that are associated with adverse consequences that could cause significant changes in condition.The nursing staff<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less).The Nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. The nurse and physician will discuss and evaluate the situation.Cause IdentificationThe staff and physician will discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, mediation regimen and diagnostic test results.Treatment/ManagementThe physician will help identify and authorize appropriate treatments.This was determined to be an Immediate Jeopardy (IJ) on 2/5/26 at 4:00 p.m. The Administrator and DON were notified and were provided with the IJ Template on 2/5/26 at 4:00 p.m. via in person and email. The following Plan of Removal was submitted by the facility and accepted on 2/6/26 at 7:43 a.m.Plan of Removal Plan for F684On 2/5/26 at 4:00 p.m., an Immediate Jeopardy (IJ) was identified related to Tag F684. The facility took immediate action to remove the jeopardy and ensure resident health and safety.Immediate Actions Taken*In-services initiated immediately in relation to notifications of Quality of Care:-Identify changes-Report Immediately-Document thoroughly-Follow facility policy-All changes in conditions - not baseline, will be notified immediately to Administrator/DON/Medical director/Primary Care Physician.*All residents were assessed by nursing staff.Protection of all Residents*All residents were assessed for potential harm related to this IJ on 2/5/26.*Any identified concerns will be addressed immediately.Staff Education*On 2/5/26, the DON was in-serviced by the Corporate RN on Quality of Care and Neurological Assessment.*Staff education was initiated regarding Quality of Care and Neurological Assessment on 2/5/26 and will be completed on 2/6/26. Any staff who cannot be in-serviced by 2/6/26 will be in-serviced before their next shift.*Education included - see attachment.*Attendance was documented.Monitoring to Ensure Ongoing Compliance*The facility-initiated monitoring beginning 2/5/26.*Monitoring includes reviewing daily 24-hour reports and conducting daily resident rounds.*The Administrator/DON/Designee will review findings daily for two weeks, then 3 times weekly for one month.Date of Compliance: 2/6/26 Monitoring of the Plan of Removal included the following: During an interview on 2/6/26 at 10:30 a.m., the DON stated she had all the paperwork for the POR in a folder. The DON stated she had the 24-hour report for this morning, which was reviewed, and things were highlighted for the doctor to be notified. The DON stated that right after the medication passes in the morning, the nurses assess every resident daily Monday through Friday for 4 weeks, then 3 times a week for one month, then once a week for one month. The DON stated they had a base line in-service covering neurological assessments and Quality of Care, and then 43 pages of what was included, and they were working on that in-service right now. The DON stated the education was ongoing as not all staff were available, but would l be in-serviced before they were allowed to work. The DON stated she had a one-on-one directed education by the corporate representative which covered the following areas: changes in condition assessments which is required for traumatic events (fall, injury) and changes in resident's baseline assessment, DON doing daily rounds, including Glascow Coma Scale in assessments, notification of primary physician and emergency contact to determine plan of care, document findings of assessment and notification in medical record. Record Review on 2/6/26 at 10:43 a.m. of the daily assessment sheet which will be used daily to assess every resident in the facility to ensure Quality of Care revealed the nurses will check any physical, behavioral or neurological concerns observed for that day. All residents were assessed from 2/5/26 t0 2/6/26 by checking current vitals, any pain concerns, reviewed progress notes. The physician and family were notified timely of two falls with no injury Record Review of the in-service sheets reflected all staff were trained on the Facility's Plan of Removal, Daily Nurse Assessment Sheet, Change in<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676079 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park View Nursing Care Center | 1100 W Ave J<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Condition, Neurological Assessment and Change in Condition, What is a Change of Condition, 24-Hour Summary Reports and Seven Components of Prevention and Detection. Included with the In-service sheets, there was a Directed Education for the DON regarding change in condition assessments and Quality of Care which included: 1. Baseline assessments for each resident, 2. Use of nursing assessment with a change of condition, 3. Notification of primary physician and emergency contact to determine plan of care, and 4. Document findings of assessment and notification in medical record. Interviews on 2/6/26 starting at 11:05 a.m., the following interviews were conducted with staff working in the facility. All staff stated they have all been in-serviced over providing Quality Care to all residents. All nurses knew about daily assessments on all residents that need to be completed, also conducting neurological and behavioral assessments to ensure the residents did not have a change of condition that needed to be reported to the charge nurse or Don, what a change on condition could be and to know each residents baseline and what to look for and how to provide the care each resident needed.Interviews conducted included the following staff:Administrator and DONCNA D, F, GLVN B, EHousekeeping HCOTA IBOM/CMA/CNA JThe following interviews were conducted by telephone of all staff working all shifts, included the following: RNs - M, N, P, TLVNs - V, AA, BB, CCCNAs - K, L, O, Q, R, S, U, W, X, Y, Z The Administrator was informed the Immediate Jeopardy was removed on 2/6/26 at 1:57 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. |