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	04/01/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 (Resident #1 and Resident #2) of 5 residents reviewed for abuse/neglect policy implementation.The facility failed to implement their abuse policy and report to state within 2 hours when Resident #2's family member alleged to RN F that Resident #1 entered Resident #2's room and hit her in the face on the evening of 03/19/26.This failure could place residents at risk of abuse and neglect occurring and/or continuing.Findings Included:Record review of Resident #1's admission record dated 04/01/26 revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) and pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder).Record review of Resident #1's quarterly MDS completed on 03/27/26 revealed a BIMS of 4 which indicated severely impaired cognition. Section E Behavior revealed Resident #1 had physical behavioral symptoms and verbal behavioral symptoms directed toward others 1-3 days of the look-back period.Record review of Resident #1's care plan completed on 02/02/26 revealed no mention of behaviors directed toward others. Resident #1 was noted to have wandering behavior.Record review of Resident #1's progress notes revealed a note by LVN A on 03/19/26 at 8:47 PM stating Resident #2's family member called RN F and stated Resident #1 was in Resident #2's room hitting Resident #2 in the face. LVN A noted CNA removed Resident #1 and Resident #1 was agitated and scratched the CNA. LVN A noted Resident #1 thought Resident #2's room was her room.Record review of Resident #2's admission record dated 04/01/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, 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), congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue), and Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement).Record review of Resident #2's significant change MDS revealed a BIMS of 14 which indicated intact cognition.Record review of Resident #2's care plan completed on 03/25/26 revealed no mention of issues or conflict with Resident #1.Record review of Resident #2's progress notes revealed the following note with corresponding date and author:A note on 03/19/26 by LVN A This nurse was doing med pass, when Co-nurse from day shift came and was on the phone with Resident's family saying that they were stating that another resident was in [Resident #2]'s room hitting her in the face. Co-nurse and CNAs went to resident's room and got co-resident out of the room and laid her down in bed. Vital signs of resident receiving physical aggression assessed . Resident's skin assessed and no noted bruising or redness. When asked resident if she was having any pain resident stated no. During med pass resident refused sleeping pill because she stated that she did not want to sleep because she did not want the other resident to go in her room again. [Physician] notified of received physical aggression and family aware due to resident calling family (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 B. Wing	04/01/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during the incident. Resident is currently sitting in recliner awake in her room, even and unlabored breathing noted. No distress noted at this time. Call light is within reach.During an interview on 04/01/26 at 10:20 AM ADM stated she was in the facility on the evening of 03/19/26 when Resident #1 was alleged to have hit Resident #2 in the face. She stated CNA E walked into Resident #2's room and saw Resident #2 attempting to push Resident #1 in her wheelchair out of Resident #2's room.During an interview on 04/01/26 at 11:11 AM CNA H stated she was trained on facility policy to report suspected abuse immediately to ADM or DON.During an interview on 04/01/26 at 11:13 AM COTA stated she was trained on facility policy to report suspected abuse immediately to ADM or DON.During an interview on 04/01/26 at 11:15 AM CNA C stated she was trained on facility policy to report suspected abuse immediately to ADM or DON.During an observation on 04/01/26 at 11:21 AM Resident #1's room was noted to be directly across the hall from Resident #2's room. Resident #2's room had an approximately 7-inch-wide strip of netting hung approximately 3 feet high across the doorway with a stop sign in the middle of the netting. The door to her room was closed behind the netting.During an observation and interview on 04/01/26 at 11:22 AM Resident #2 was seated in the recliner in her room. She stated she had had issues with Resident #1 coming into her room. She stated the last time Resident #1 came into her room she (Resident #2) made the mistake of getting in front of Resident #1 and Resident #1 kicked her in the shins and hit her in the face. She stated it did not hurt. Resident #2 stated she got behind Resident #1 and started pushing her in her wheelchair toward the door of the room when Resident #1 caught the partially open door with her foot and kicked it closed. Resident #2 stated she reopened the door and was attempting to push Resident #1 out the door when CNAs came in and wheeled Resident #1 out of her room. Resident #2 stated after the incident staff offered to move her to a room on another hall, but she declined as she likes her current room.During an interview on 04/01/26 at 11:38 AM HSK stated she had been trained on facility's policy to report abuse immediately to ADM or DON.During an interview on 04/01/26 at 11:55 AM RN F stated Resident #1 had dementia and would frequently go into other residents' rooms and use their bathrooms. She stated Resident #1 had not been physically aggressive with other residents to her knowledge. RN F stated Resident #1 had difficulty hearing and seeing and those conditions combined with her dementia caused her to get resistive to care and occasionally physically aggressive with staff if they did not slowly explain to her what they were going to do when moving her in her wheelchair or providing care for her. RN F stated Resident #1 would hit and/or kick at staff when she became upset or confused. She stated she was trained on the facility policy to report abuse immediately at least weekly.During an observation and attempted interview on 04/01/26 at 01:40 PM Resident #1 was in the hospital in her bed with the head of the bed raised to seated position. She stated she was doing okay. Resident #1 appeared unable to hear questions regarding altercation with Resident #2 and/or unwilling to answer said questions.During an interview on 04/01/26 at 03:53 PM Resident #2's family member stated Resident #2 called her on 03/19/26 to say Resident #1 tried to get in her room again and hit her. Resident #2's family member stated she visited Resident #2 at the facility and Resident #2 seemed to be okay and not worried and there was not a mark on her. She stated that Resident #2 told her she wished she had not said anything because she did not want to get Resident #1 in trouble. Resident #2's family member stated she did not think Resident #1 hurt Resident #2 in the altercation. She stated the facility offered to move Resident #2 to a hall away from Resident #1 but Resident #2 was having enough trouble adjusting to being in the facility and the family agreed a room change was not a good idea at the time.During an interview on 04/01/26 at 04:24 PM DON stated she expected staff to report suspected abuse immediately to her and/or ADM. She stated a possible negative outcome of not reporting suspected abuse immediately was it would continue.During an interview on 04/01/26 at 04:48 PM ADM stated suspected abuse was to be reported immediately to her or DON and within 2 hours to the state, otherwise a resident would be negatively affected. She stated LVN A would be disciplined for not reporting the incident between Resident #1 and Resident #2 immediately. She stated she thought the timing was off, that the incident happened earlier in the day and not when (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 B. Wing	04/01/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's family called RN F. She stated when the family called RN F and LVN A went to the doorway of Resident #2's room and spoke to her but Resident #1 was not in her room at that time.During an interview on 04/01/26 at 05:07 PM Resident #1's family member stated he was notified Resident #1 went into another resident's room and was physically aggressive. He stated, But I mean she's (Resident #1) got dementia, she doesn't know. She is not doing it on purpose.During an interview on 04/01/26 at 05:35 PM ADON stated she expected staff to report suspicion of abuse immediately to her, DON, or ADM. She stated she and DON had trained staff 'til we are blue in the face on reporting abuse and neglect. She stated a possible negative outcome of not reporting abuse immediately was more harm or damage could happen to a resident.During an interview on 04/01/26 at 06:02 PM RN F stated on 03/19/26 she was staying late in the facility to chart, and she answered the phone at the nurses' station. She stated it was Resident #2's family member calling to say another resident was in Resident #2's room hitting Resident #2. She stated she and LVN A ran down the hall to Resident #2's room and no one was in the room except Resident #2. She stated Resident #2 did not appear to be injured. She stated she told LVN A to report the allegation.During an interview on 04/01/26 at 06:12 PM CNA G stated she was trained regularly on the facility policy of reporting suspected abuse immediately to DON or ADM.During an interview on 04/01/26 at 06:33 PM CNA D stated she was trained regularly on the facility policy of reporting suspected abuse immediately to DON or ADM.During an interview on 04/01/26 at 06:46 PM DON stated LVN A texted the on-call phone which was in her (DON's) possession at 07:24 PM on 03/19/26 regarding the incident between Resident #1 and Resident #2. She stated she was already asleep and did not wake up to the text message. She stated she had a talk with LVN A and told her to call and not text in the future.During an interview on 04/01/26 at 07:35 PM LVN A stated she sent a text to the on-call phone regarding the incident between Resident #1 and Resident #2 on 03/19/26. She stated ADM was in the building at the time of the incident and she believed ADM went down the hall with her and RN F to check on Resident #2 when Resident #2's family member called. She stated when they got to Resident #2's room Resident #1 had already been removed from the room by a CNA. She stated she was trained on the facility policy of reporting suspected abuse immediately to DON or ADM.During an interview on 04/02/26 at 02:37 PM CNA E stated on the evening of 03/19/26 she was headed to Resident #1's room to put her to bed and she found Resident #1 across the hall in Resident #2's room. She stated she saw Resident #2 in her wheelchair behind Resident #1 who was in her wheelchair. CNA E stated Resident #2 was attempting to push Resident #1 out of her room. She stated she went in and wheeled Resident #1 out of Resident #2's room. CNA E stated when she entered Resident #2's room to retrieve Resident #1, Resident #2 said, Oh good, how did you know she (Resident #1) was in here (Resident #2's room)? CNA E stated, A little bit after that the nurse received a phone call from Resident #2's family member and they thought and incident occurred right then and there, but I had already put Resident #1 in her room. She stated she informed LVN A and RN F of finding Resident #1 in Resident #2's room earlier in the evening. She stated Resident #2 was shaken up that evening and kept calling staff until 10 (PM) or midnight to make sure Resident #1 was not in her room. She stated she was trained on the facility's policy of reporting suspected abuse immediately.Record review of facility policy titled Abuse and Neglect - Clinical Protocol and dated 2001 revealed the following, . The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.Record review of an undated facility policy titled Abuse, Neglect, and Incident Reporting Requirement revealed the following: All staff are required to immediately report any suspected or alleged abuse, neglect, exploitation, misappropriation of resident property, or unusual incident to the Administrator and Director of Nursing (DON). All reports must remain confidential and only shared with appropriate leadership and regulatory authorities.Record review of an undated facility policy titled CMS F600/F609 Abuse Reporting revealed the following: All allegations must be reported immediately. Immediate reporting to Administrator/DON . Timely reporting to state (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 B. Wing	04/01/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorities .Record review of an undated facility New Employee Orientation packet reveals the following: . Report and Investigate . The facility will put in place measures that facilitate and assure the reporting of abuse and neglect within 2 hours of identification or allegation .

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	04/01/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #1 and Resident #2) of 5 residents reviewed for reporting of abuse/neglect allegations.The facility failed to report to state within 2 hours when on 03/19/26 Resident #2's family member alleged to RN F that Resident #1 hit Resident #2 in the face.This failure could place residents at risk of continued abuse/neglect.Findings Included:Record review of Resident #1's admission record dated 04/01/26 revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) and pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder).Record review of Resident #1's quarterly MDS completed on 03/27/26 revealed a BIMS of 4 which indicated severely impaired cognition. Section E Behavior revealed Resident #1 had physical behavioral symptoms and verbal behavioral symptoms directed toward others 1-3 days of the look-back period.Record review of Resident #1's care plan completed on 02/02/26 revealed no mention of behaviors directed toward others. Resident #1 was noted to have wandering behavior.Record review of Resident #1's progress notes revealed a note by LVN A on 03/19/26 at 8:47 PM stating Resident #2's family member called RN F and stated Resident #1 was in Resident #2's room hitting Resident #2 in the face. LVN A noted CNA removed Resident #1 and Resident #1 was agitated and scratched the CNA. LVN A noted Resident #1 thought Resident #2's room was her room.Record review of Resident #2's admission record dated 04/01/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, 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), congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue), and Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement).Record review of Resident #2's significant change MDS revealed a BIMS of 14 which indicated intact cognition.Record review of Resident #2's care plan completed on 03/25/26 revealed no mention of issues or conflict with Resident #1.Record review of Resident #2's progress notes revealed the following note with corresponding date and author:A note on 03/19/26 by LVN A This nurse was doing med pass, when Co-nurse from day shift came and was on the phone with Resident's family saying that they were stating that another resident was in [Resident #2]'s room hitting her in the face. Co-nurse and CNAs went to resident's room and got co-resident out of the room and laid her down in bed. Vital signs of resident receiving physical aggression assessed . Resident's skin assessed and no noted bruising or redness. When asked resident if she was having any pain resident stated no. During med pass resident refused sleeping pill because she stated that she did not want to sleep because she did not want the other resident to go in her room again. [Physician] notified of received physical aggression and family aware due to resident calling family during the incident. Resident is currently sitting in recliner awake in her room, even and unlabored breathing noted. No (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 B. Wing	04/01/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distress noted at this time. Call light is within reach.During an interview on 04/01/26 at 10:20 AM ADM stated she was in the facility on the evening of 03/19/26 when Resident #1 was alleged to have hit Resident #2 in the face. She stated the CNA E walked into Resident #2's room and saw Resident #2 attempting to push Resident #1 in her wheelchair out of Resident #2's room. She stated Resident #2 was offered a room on another hall further away from Resident #1, but she declined. She stated Resident #1 was out of the facility at the hospital and when she returned the facility planned to move her into a room on a different hall.During an observation on 04/01/26 at 11:21 AM Resident #1's room was noted to be directly across the hall from Resident #2's room. Resident #2's room had an approximately 7-inch-wide strip of netting hung approximately 3 feet high across the doorway with a stop sign in the middle of the netting. The door to her room was closed behind the netting.During an observation and interview on 04/01/26 at 11:22 AM Resident #2 was seated in the recliner in her room. She stated she had had issues with Resident #1 coming into her room. She stated the last time Resident #1 came into her room she (Resident #2) made the mistake of getting in front of Resident #1 and Resident #1 kicked her in the shins and hit her in the face. She stated it did not hurt. Resident #2 stated she got behind Resident #1 and started pushing her in her wheelchair toward the door of the room when Resident #1 caught the partially open door with her foot and kicked it closed. Resident #2 stated she reopened the door and was attempting to push Resident #1 out the door when CNAs came in and wheeled Resident #1 out of her room. Resident #2 stated after the incident staff offered to move her to a room on another hall, but she declined as she likes her current room.During an interview on 04/01/26 at 11:55 AM RN F stated Resident #1 had dementia and would frequently go into other residents' rooms and use their bathrooms. She stated Resident #1 had not been physically aggressive with other residents to her knowledge. RN F stated Resident #1 had difficulty hearing and seeing and those conditions combined with her dementia caused her to get resistive to care and occasionally physically aggressive with staff if they did not slowly explain to her what they were going to do when moving her in her wheelchair or providing care for her. RN F stated Resident #1 would hit and/or kick at staff when she became upset or confused.During an observation and attempted interview on 04/01/26 at 01:40 PM Resident #1 was in the hospital in her bed with the head of the bed raised to seated position. She stated she was doing okay. Resident #1 appeared unable to hear questions regarding altercation with Resident #2 and/or unwilling to answer said questions.During an interview on 04/01/26 at 03:53 PM Resident #2's family member stated Resident #2 called her on 03/19/26 to say Resident #1 tried to get in her room again and hit her. Resident #2's family member stated she visited Resident #2 at the facility and Resident #2 seemed to be okay and not worried and there was not a mark on her. She stated that Resident #2 told her she wished she had not said anything because she did not want to get Resident #1 in trouble. Resident #2's family member stated she did not think Resident #1 hurt Resident #2 in the altercation.During an interview on 04/01/26 at 04:24 PM DON stated she expected staff to report suspected abuse immediately. She stated a possible negative outcome of not reporting suspected abuse immediately was it would continue.During an interview on 04/01/26 at 04:48 PM ADM stated suspected abuse was to be reported immediately to DON or ADM and within 2 hours to the state, otherwise a resident would be negatively affected. She stated LVN A would be disciplined for not reporting the incident between Resident #1 and Resident #2 immediately. She stated she thought the timing was off, that the incident happened earlier in the day and not when Resident #2's family called RN F. She stated when the family called RN F and LVN A went to the doorway of Resident #2's room and spoke to her but Resident #1 was not in her room at that time.During an interview on 04/01/26 at 05:07 PM Resident #1's family member stated he was notified Resident #1 went into another resident's room and was physically aggressive. He stated, But I mean she's (Resident #1) got dementia, she doesn't know. She is not doing it on purpose.During an interview on 04/01/26 at 05:35 PM ADON stated she expected staff to report suspicion of abuse immediately to her, DON, or ADM. She stated she and DON had trained staff 'til we are blue in the face on reporting abuse and neglect. She stated a possible negative outcome of not reporting abuse (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 B. Wing	04/01/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately was more harm or damage could happen to a resident.During an interview on 04/01/26 at 06:02 PM RN F stated on 03/19/26 she was staying late in the facility to chart, and she answered the phone at the nurses' station. She stated it was Resident #2's family member calling to say another resident was in Resident #2's room hitting Resident #2. She stated she and LVN A ran down the hall to Resident #2's room and no one was in the room except Resident #2. She stated Resident #2 did not appear to be injured. She stated she told LVN A to report the allegation.During an interview on 04/01/26 at 06:46 PM DON stated LVN A texted the on-call phone which was in her (DON's) possession at 07:24 PM on 03/19/26 regarding the incident between Resident #1 and Resident #2. She stated she was already asleep and did not wake up to the text message. She stated she had a talk with LVN A and told her to call and not text in the future.During an interview on 04/01/26 at 07:35 PM LVN A stated she sent a text to the on-call phone regarding the incident between Resident #1 and Resident #2 on 03/19/26. She stated ADM was in the building at the time of the incident and she believed ADM went down the hall with her and RN F to check on Resident #2 when Resident #2's family member called. She stated when they got to Resident #2's room Resident #1 had already been removed from the room by a CNA.During an interview on 04/02/26 at 02:37 PM CNA E stated on the evening of 03/19/26 she was headed to Resident #1's room to put her to bed and she found Resident #1 across the hall in Resident #2's room. She stated she saw Resident #2 in her wheelchair behind Resident #1 who was in her wheelchair. CNA E stated Resident #2 was attempting to push Resident #1 out of her room. She stated she went in and wheeled Resident #1 out of Resident #2's room. CNA E stated when she entered Resident #2's room to retrieve Resident #1, Resident #2 said, Oh good, how did you know she (Resident #1) was in here (Resident #2's room)? CNA E stated, A little bit after that the nurse received a phone call from Resident #2's family member and they thought and incident occurred right then and there, but I had already put Resident #1 in her room. She stated she informed LVN A and RN F of finding Resident #1 in Resident #2's room earlier in the evening. She stated Resident #2 was shaken up that evening and kept calling staff until 10 (PM) or midnight to make sure Resident #1 was not in her room.Record review of facility policy titled Abuse and Neglect - Clinical Protocol and dated 2001 revealed the following, . The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.Record review of an undated facility policy titled Abuse, Neglect, and Incident Reporting Requirement revealed the following: All staff are required to immediately report any suspected or alleged abuse, neglect, exploitation, misappropriation of resident property, or unusual incident to the Administrator and Director of Nursing (DON). All reports must remain confidential and only shared with appropriate leadership and regulatory authorities.Record review of an undated facility policy titled CMS F600/F609 Abuse Reporting revealed the following: All allegations must be reported immediately. Immediate reporting to Administrator/DON . Timely reporting to state authorities .Record review of an undated facility New Employee Orientation packet reveals the following: . Report and Investigate . The facility will put in place measures that facilitate and assure the reporting of abuse and neglect within 2 hours of identification or allegation .

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	04/01/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #3) of 5 residents reviewed for medication administration.The facility failed to ensure LVN B administered Resident #3's morning medications within an hour of the ordered time on 03/29/26.This failure could place residents at risk of increased disease symptoms and/or diminished quality of life.Findings Included:Record review of Resident #3's admission record dated 04/01/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified focal traumatic brain injury with loss of consciousness of unspecified duration sequela (condition resulting from a head injury that leads to specific focal brain damage with long-term effects/complications), post traumatic seizures (seizures that result from a traumatic brain injury), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and other muscle spasm (involuntary, sudden, and often painful contraction of a muscle that cannot relax immediately).Record review of Resident #3's quarterly MDS completed 01/15/26 revealed a BIMS of 3 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #3 was dependent across all ADLs.Record review of Resident #3's care plan completed on 02/02/26 revealed the following: . Altered Comfort due to pain R/T bilateral upper and lower extremity contractures, a history of healed fractures and TBI . Analgesics (pain medications) as ordered. Tizanidine (muscle relaxer) as ordered . I have seizure disorder related to TBI . Give seizure medication as ordered by doctor. I am at risk for falls . ensure he is not at edge of bed, [Resident #3] will wiggle and wiggle out of bed to floor.Record review of Resident #33's Order Summary Report dated 04/01/26 revealed the following orders: Cholecalciferol Oral Tablet 25 MCG . Give 3 tablet via G-Tube one time a day related to VITAMIN D DEFICIENCY . Multivitamin Adult Oral Tablet (Multiple Vitamin) Give 1 tablet via G-Tube one time a day related to VITAMIN D DEFICIENCY . Chlorhexidine Gluconate Mouth/Throat Solution 0.12% . Give 15 ml by mouth two times a day for mouth wash twice a day . diazepam Oral Tablet 5 MG . give 1 tablet via G-Tube two times a day related to ANXIETY DISORDER. Docusate Sodium Oral Tablet 100 MG . Give 1 tablet via G-Tube two times a day . levetiracetam Oral Solution 500 MG/5ML . Give 5 ml via G-Tube two times a day related to UNSPECIFIED FOCAL TRAUMATIC BRAIN INJURY WITH LOSS OF CONCIOUSNESS OF UNSPECIFIED DURATION SEQUELA . Baclofen Oral Tablet 5 MG . Give 1 tablet via G-Tube three times a day . related to OTHER MUSCLE SPASM . Buspirone HCl Oral Tablet 10 MG . Give 1 tablet via PEG-Tube three times a day related to ANXIETY DISORDER . tizanidine HCl Oral Tablet 4 MG . Give 2 tablet via G-Tube three times a day related to OTHER MUSCLE SPASM . Enteral Feed Order four times a day Nutren 2.0 250 cc per g-tube 4 times per day .Record review of Resident #3's MAR for March 2026 revealed the following medications with corresponding order times were administered on the morning of 03/29/26 by LVN B.08:00 AM Cholecalciferol Oral Tablet 25 MCG . Give 3 tablet via G-Tube one time a day related to VITAMIN D DEFICIENCY .08:00 AM Multivitamin Adult Oral Tablet (Multiple Vitamin) Give 1 tablet via G-Tube one time a day related to VITAMIN D DEFICIENCY .08:00 AM Chlorhexidine Gluconate Mouth/Throat Solution 0.12% . Give 15 ml by mouth two times a day for mouth wash twice a day .08:00 AM diazepam Oral Tablet 5 MG . give 1 tablet via G-Tube two times a day related to ANXIETY DISORDER.08:00 AM Docusate Sodium Oral Tablet 100 MG . Give 1 tablet via G-Tube two times a day .08:00 AM levetiracetam Oral Solution 500 MG/5ML . Give 5 ml via G-Tube two times a day related to UNSPECIFIED FOCAL TRAUMATIC BRAIN INJURY WITH LOSS OF CONCIOUSNESS OF UNSPECIFIED DURATION SEQUELA .08:00 AM Baclofen Oral Tablet 5 MG . Give 1 tablet via G-Tube three times a day . related to OTHER MUSCLE SPASM .08:00 (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 B. Wing	04/01/2026

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	AM Buspirone HCl Oral Tablet 10 MG . Give 1 tablet via PEG-Tube three times a day related to ANXIETY DISORDER .08:00 AM tizanidine HCl Oral Tablet 4 MG . Give 2 tablet via G-Tube three times a day related to OTHER MUSCLE SPASM .09:00 AM Enteral Feed Order four times a day Nutren 2.0 250 cc per g-tube 4 times per day .Record review of Resident #3's progress notes revealed the following notes with corresponding date, time, and author:A note from 03/29/26 at 11:11 AM by LVN B Resident found by writer on the floor of his room. The resident was lying between the bed and the wall. Fall is unwitnessed. The bed was pushed away from the wall. It was noted by writer that the resident did not have any injuries and there was no noted distress. Resident assisted back to bed by writer and two CNAs. Family, physician, and on-call nurse notified via telephone.A note from 03/29/26 at 02:39 PM by DON Spoke with POA [Resident #3's family member] about resident [Resident #3's name]. [Family member] stated that she had received a phone call from charge nurse [LVN B], LVN that [Resident #3] had fallen between his bed and the wall. The nurse ask [sic] [Family member] to view footage from her camera to see how the fall had occurred as [Resident #3]'s roommate had been in the room and she was afraid he might have caused the fall. [Family member] said according to the camera footage which she started from the time the night CNA went in to change him which was a little before 5am until 10:50am no one entered the room. [Family member] was especially concerned that his 8:00am [sic] medications had no [sic] been given. [Family member] said [Resident #3]'s movements become exaggerated and squirmy when he does not get his medications on time. [Family member] called up here to ask the nurse (LVN B) why she had not given him his am (AM) medications and the nurse (LVN B) told [family member] that she had administered his medications. [Family member] stated that [Resident #3] had become so squirmy that he had literally squirmed himself off the bed.During an observation and interview on 04/01/26 at 10:04 AM Resident #3 was seated in his specialized wheelchair in the common area in front of the television. He had physical therapy carrots on both hands for his hand contractures. He was dressed neatly and his hair appeared to be recently combed. Resident #3 nodded his head indicating yes when asked if staff were kind to him and taking good care of him.During an interview on 04/01/26 at 11:15 AM CNA C stated she was working as a facility floater (someone who helps out the CNAs assigned to every hall as needed) on 03/29/26 when Resident #3 fell out of his bed. She stated the nurse found Resident #3 on the floor and asked for assistance putting him back to bed. CNA C stated, When I went in there he was between the bed and the wall on the floor. The bed was moved out. I think he kicked it and scooted it out from the wall. He was laughing about it. She stated the night CNA told her Resident #3 was moving around in his bed a lot that night.During an observation on 04/01/26 at 11:17 AM of Resident #3's room it was noted a person standing in the doorway of his room observing his bed would not be picked up by the camera in his room due to the position of the camera and the location of his television.During an interview on 04/01/26 at 11:55 AM RN F stated she was working on 03/29/26 but she was not assigned to Resident #3's hall. She was moved to his hall after his fall. RN F stated, I did go and check him out afterward (after the fall) and switched to his hall and he had no issues he was happy .During an interview on 04/01/26 at 03:40 PM Resident #3's family member stated on the morning of 03/29/26 around 11:00 AM LVN B called her and asked her to review the camera footage from Resident #3's room due to him falling out of bed. Resident #3's family member stated she reviewed the camera footage and noticed no staff member entered his room from approximately 05:00 AM until LVN B walked in and found him on the floor. She stated Resident #3's roommate appeared to find him on the floor and leave to alert LVN B. Resident #3's family member stated she called DON to tell her what she found during her review of the camera footage.During an interview on 04/01/26 at 04:24 PM DON stated on 03/29/26 she spoke to LVN B and LVN B told her she gave Resident #3 his medications at 10:50 AM. However, DON stated she had Resident #3's family member bring her the video footage to review. She stated according to the video footage at 10:53 AM Resident #3 fell on the floor and his roommate walked over and said something to him and left the room. At 11:09 LVN B entered the room for the first time followed by Resident #3's roommate and found Resident #3 on the (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 B. Wing	04/01/2026

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	floor. DON stated prior to falling, Resident #3 was moving around in his bed and was kicking the wall causing his bed to move away from the wall each time he kicked. DON stated it was absolutely an issue that the nurse did not see Resident #3 until 11:09 AM. She stated, Somebody should have checked on that poor boy. DON stated, If he doesn't get his meds all of his movements get exaggerated. She stated, He has a lot of spasticity and less ability to control that spasticity when his medications are not administered in a timely manner. DON stated staff have one hour before and one hour after the ordered time shown on the MAR to administer medications to residents and she expects them to do so. She stated any time after 09:00 AM was considered late administration for Resident #3 morning medications. She stated LVN B was an agency nurse, and she called the agency to say she did not want LVN B in her facility anymore. DON stated if a nurse administered medications late she was to note that on the MAR according to facility policy.During an interview on 04/01/26 at 04:48 PM ADM stated residents could be negatively impacted if their medications were not administered in a timely manner. She stated, Well, they need their meds for a reason, it might mess with their care.During an interview on 04/01/26 at 05:35 PM ADON stated she expected nurses to administer medications ordered at 08:00 AM on the MAR between 07:00 AM and 09:00 AM. She stated a resident's health could be negatively affected by late medication administration. She stated in Resident #3's case his muscle spasms could worsen if he did not receive his scheduled baclofen (muscle relaxer). During an interview on 04/01/26 at 06:12 PM CNA G stated she worked the night shift ending on 03/29/26 at 6 AM. She stated Resident #3 usually squirms and wiggles throughout the night. She stated his behavior on the night in question was not out of the ordinary.During an interview on 04/01/26 at 06:33 PM CNA D stated she was on the day shift on Resident #3's hall on 03/29/26. She stated she was getting residents up, dressed, and fed and she stopped by Resident #3's room several times and looked in on him and spoke to him. She stated when LVN B found Resident #3 on the floor she had just seen him in his bed approximately 10 minutes prior. CNA D stated when she, CNA C, and LVN B went in to put Resident #3 back in his bed he was laughing and smiling. She stated he did not seem to be in any pain or to be scared.During an interview on 04/02/26 at 10:01 AM LVN B stated she had her medication cart outside Resident #3's room the morning of 03/29/26 and was talking to him. She stated, He likes when you just chat with him. LVN B stated she had had some issues with other residents and when she went into Resident #3's room he was on the floor. She stated she called Resident #3's family member to ask her to review the camera footage and find out what happened. LVN B stated Resident #3's family member never said what happened because she was more concerned about Resident #3 getting his feeding and his medications late. (at this point the phone call cut off)During an interview on 04/02/26 at 10:26 AM LVN B stated she gave Resident #3 his medications late. She stated she was not sure what time she gave him his morning feed and medications, but she thought it was around 10:00 or 10:30 AM. She stated she was not sure what time he was supposed to get his morning medications off the top of her head because she did not work regularly in the facility as she was agency staff. LVN B stated she did not think Resident #3 was negatively impacted by receiving his medications late.Record review of facility policy titled Administering Medications and dated April 2019 revealed the following: . Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. 7. Medications are administered within one 91) hour of their prescribed time .Record review of facility policy titled Administering Medications through an Enteral Tube and dated November 2018 revealed the following: . Follow medication administration guidelines in the policy entitled Administering Medications.