

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Park View Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen when they failed to: A. Ensure facility staff wore hair restraints and beard guards while in the kitchen. B. Ensure stored and cooked food was properly labeled, dated and covered. C. Ensure hand hygiene and use of proper serving utensils was maintained during serving a meal. D. Ensure menu substitutions were documented. These failures placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings included: In an observation of the walk-in freezer on 1/13/26 at 10:40 am revealed the following: opened box of biscuits, open to air and unsecured. 15 bags of waffles, not in original box, no label or date 3 bags of hamburger patties, not in original box, no label or date 6 bags of pancakes, not in original box, no label or date 3 bags of chicken strips, not in original box, no label or date. In an observation and interview on 1/13/26 at 11:20 am revealed [NAME] C had touched various kitchen surfaces with her gloved hands, walked to the serving table, picked up a serving dish and tongs and placed sausage in a pan. [NAME] C then took the sausage to the puree station and picked up the sausage links with her gloved hands and tore the sausage links into pieces with her gloved hands and proceeded to put the lid on the blender and puree the meat. When asked about touching the meat, [NAME] C stated, I am not supposed to do that. She stated it could cause food borne illness. In an observation and interview of the kitchen prep table on 10/13/26 from 11:30 am to 12:05 pm, revealed 6 individual plates sitting on the counter uncovered. As the remaining foods were pureed the plates of meat sat on the counter with no covering. [NAME] F stated the meat was for the noon meal for residents with pureed food. The pureed meat was plated at 11:25 am and the first plate went out at 12:15. The remaining 5 plates continued to sit on the counter uncovered until 12:16 pm when the plates were covered and put into the warmer. In an observation and interview on 1/13/26 at 11:50 am revealed the DM was in the kitchen with her hair in 2 braids on each side of her head not contained by a hairnet, TA B in the kitchen with no beard covering on his face, TA A in the kitchen with no beard cover. In a group interview the Cooks A and B both stated they should have had beard coverings but there were no beard coverings. The DM stated the staff should have beard covers but the kitchen had none. TA A stated they had masks from covid they could put on for beard guards until the beard covers came in. The DM stated she had forgotten her braids were not contained in the hairnet. She stated all hair should be covered with a hairnet and beards must be covered or shaved off. The DM stated the consequences of not having hair nets containing all hair would be food borne illness. In an observation and interview on 1/13/26 at 12:26 pm [NAME] C was observed plating food for the noon meal. [NAME] C touched plates tray cards, the counter and serving utensils with her gloved hands. [NAME] C picked up a plate, plated the food then picked up a dinner roll with her gloved hand. [NAME] C placed the plate on the tray then picked up another plate, picked up utensils and plated the meal. [NAME] C picked up a roll with her gloved hand and placed the roll on the plate. The DM was also present and stated [NAME] C should have used tongs for the bread. The DM went to [NAME] C and stated she needed to use the tongs sitting on the bread to serve bread. [NAME] C stated she had forgotten. The DM stated food borne illness would be the result of improper hand hygiene and (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	touching food. In a record review of the facility menu substitution list for the past 4 months, there were no listed meal items for January. The substitution list did not have the substitute of carrots for onions and peppers for residents on a pureed diet for the lunch meal on 1/13/26. In an interview on 1/15/26 at 1:50 pm, the DM stated she had trained staff to put the receiving date on food when it is received, the open date when opened and the use by date when taken out of a box. She stated she had not been aware this had not been done. The DM stated she was not aware the temperature of foods was supposed to be taken at the time of the meal service. She stated she and the staff had been taking the temperatures of the food after the food had been prepared and when it was first put on the steam table after preparing. She stated the times food was put on the table were at different times before the meal service and was not right before serving. She stated she had not been aware the foods temperatures needed to be done just before service began. She confirmed the food sometimes sat on the tray line for over an hour at times. The DM stated she was aware the pureed meats had been sitting on the counter for over 30 minutes and were uncovered. She stated that food borne illness could result from all these issues. Record review of the facility policy titled ' Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices' dated 2001 documented: Employees must wash hands before coming into contact with any food surfaces, after handling soiled equipment or utensils, during food preparations as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks Contact between food and bare hands is prohibited. Gloves are considered single use items and must be discarded after completing the task for which they are used. Gloves are removed abd hands are washed and gloves are replaced. The use of disposable gloves does not replace proper handwashing.Food Service employees are trained in the proper use of tongs, gloves and spatulas in order to prevent food borne illness. Hairnets and beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. Record review of the facility's policy titled, 'Food Receiving and Storage' dated 2001, documented: All foods must be covered, labeled and dated (use by date)Wrappers of frozen foods must stay intact until thawing. Record review of the facility's policy titled, ' Nutrient Retention of Foods' dated 2001, documented: Food will not be held for more than one hour before service, preparation, thawing or reheating.Staff will work to minimize holding time as much as possible. Record review of the facility's policy titled, ' Menus ' dated 2001, documented: Deviations from posted menu are recorded including the reason for the substitution and/ or deviation and archived.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles to include the appropriate accessory and cautionary instructions, and the expiration date when applicable on 2 (Hall 100 and Hall 200) of 2 medication carts. -1 bottle of Probiotic had an expiration date of 11/2025.-1 bottle of Tylenol had an expiration date of 10/2019.-Resident #1's Novolog did not have an open date on the medication.-Resident #36's Novolog and Lantus did not have open dates on the medications.-Resident #37 had 2 Wexela inhalers that did not have open dates written on the medications-Resident #37's 2-Wexela inhalers had expiration dates of 07/2023 and 10/2023.-2 loose pills were in the bottom of Medication cart for Hall 200. -Half of a loose pill was in the bottom of the narcotic drawer of Medication cart for Hall 100.The facility's failure could place residents at risk for not receiving the intended therapeutic action of the medication.Findings included:During an observation on 01/13/2026 at 10:19 AM of the Hall 200 medication cart with LVN D revealed the following: 1 bottle of Probiotic with an expiration date of 11/2025 and a bottle of Tylenol with the expiration date of 10/2019. 2 loose pills were discovered in the bottom of the medication cart drawers and Resident #1's Novolog flex pen did not have an open date on it. Resident #36's Novolog and Lantus insulin pens did not have open dates. During an interview on 01/13/2026 at 10:35 AM LVN D stated the negative outcome for not having open dates on insulin could be the medication could be expired and not as effective for the resident. LVN D stated the negative outcome of having loose pills could lead to a possible missed dose of medication for the residents. During an observation on 01/13/2026 at 11:49 AM of the Hall 100 medication cart with LVN E revealed the following:a half of a pill loose in the bottom of the narcotic medication drawer, and 2 inhalers of Wexela for Resident #37 with no open dates written on the inhalers and expiration dates for 10/2023 and 07/2023. During an interview on 01/13/2026 at 12:01 PM LVN E stated the negative outcome for not having open dates on medications could lead to the medication being expired the medication having a decreased effectiveness for the resident. LVN E stated that negative outcome for having loose pills in the medication cart could lead to a missed dose of medication for the resident. During an interview on 01/15/2026 at 1:44 PM DON stated a negative outcome for not having open dates on medications that required one could lead to residents receiving expired medications. DON stated the negative outcome for loose pills was that the residents could be missing doses.Record review of policy titled, Medication Labeling and Storage, undated, revealed the following: .Medication Storage.2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems.Medication Labeling.2. The medication label includes, at a minimum: .d. expiration date, when applicable; . 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded withing 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Record review of policy titled, Administering Medication, revised April 2019, revealed the following: .12. The expiration/beyond use date on the medication label is checked before administering. When opening a multi-dose container, the date opened is recorded on the container. Record review of policy titled, Insulin Administration, September 2014, revealed the following: .Steps in the Procedure (Insulin Injections via Syringe).4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review; it was determined the facility failed to ensure each resident was provided with the right to have personal privacy during medical treatments, for 1 (Resident #8) of 13 residents reviewed for privacy. -RN G and CNA I did not close the window blinds to provide privacy for Resident #8 during wound care. This failure could place residents at risk of feeling shame or embarrassment, lowered self-esteem, and a lack of a dignified existence. Findings Included: Resident #8 Record review of Resident #8's clinical record revealed a [AGE] year-old male, who was admitted to the facility on [DATE] with diagnoses of myelodysplastic syndrome (the bone marrow produces faulty, immature blood cells that don't mature properly, leading to too few healthy red cells (anemia), white cells (infections), and platelets (bleeding)), schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with a mood disorder (major depression or bipolar mania), characterized by psychosis occurring for at least two weeks without mood symptoms), bipolar disorder (a serious mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with a mood disorder (major depression or bipolar mania), characterized by psychosis occurring for at least two weeks without mood symptoms), and pain. Record review of Resident #8's most recent MDS assessment, dated 10/03/2025, indicated Resident #8 had a BIMS of 13, indicated no cognitive impairment and a functionality of total dependency assistance was required with showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Maximal assistance was required with toileting hygiene, supervision or touching assistance was required with oral hygiene, and set-up or clean-up assistance was required for eating. During an observation on 01/14/2026 at 11:52 AM, RN G and CNA I provided Resident #8 with wound care, they did not close the window blinds. During an interview on 01/14/2026 at 12:03 PM RN G stated a negative outcome for the blinds not being closed was someone could walk by the window and see the residents bloody wound. During an interview on 01/15/2026 at 1:44 PM 01/15/2026 DON stated a negative outcome for not closing blinds during wound care could lead to someone walking by and seeing the resident in a compromising situation, plus it is a dignity issue. Record review of policy titled, Residents Rights, revised December 2016, revealed the following: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity; . t. privacy and confidentiality;. Record review of policy titled, Confidentiality of Information and Personal Privacy, revised October 2017, revealed the following: Policy Statement Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation .2. The facility will strive to protect the resident's privacy regarding his or her: .b. medical treatment; .		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #2) of 13 residents reviewed for accuracy of assessment. The facility coded Resident #2 as receiving insulin when she did not receive insulin. This failure could place residents at risk of receiving unnecessary care/medication. Findings Included: Record review of Resident #2's admission record dated 01/13/26 revealed an [AGE] year-old female 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), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and unspecified atrial fibrillation (irregular heart rhythm). Record review of Resident #2's annual MDS with ARD of 10/14/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section N Medications revealed the following: . N0350 Insulin A. Insulin injections Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. The numeral one was entered into the box supplied to record the number of days, which indicated Resident #2 received insulin one day from 10/07/25 to 10/14/25. Record review of Resident #2's care plan completed on 11/19/25 revealed no mention of insulin. Record review of Resident #2's active orders revealed no order for insulin. Record review of Resident #2's discontinued, struck out, and completed orders revealed no order for insulin. Record review of Resident #2's MAR for October 2025 revealed no insulin was administered to Resident #2 at any time during the month. During an observation on 01/14/26 at 08:30 AM LVN F was administering medication to Resident #2 at her bedside. During an interview on 01/14/26 at 08:35 AM LVN F stated she had worked for the facility for 6 months and Resident #2 had not received insulin during that time. During an interview on 01/15/26 at 10:17 AM CNA H stated she did not know if having an inaccurate MDS would negatively impact the resident. During an interview on 01/15/26 at 10:20 AM LVN F stated she did know if having an inaccurate MDS would negatively impact the resident. During an interview on 01/15/26 at 10:35 AM RN G stated an inaccurate MDS assessment could possibly impact the resident negatively. She stated Resident #2 did not receive insulin. During an interview on 01/15/26 at 10:59 AM ADON stated a corporate staff member had been responsible for MDS assessments until 01/01/26 when MDS LVN took over the responsibility. She stated a resident could be negatively impacted by an inaccurate MDS assessment. She stated the resident might not get the care they need and the MDS assessment affected funding so the facility might not get needed funding to provide care to residents. She stated Resident #2 did not receive insulin. During an interview on 01/15/26 at 11:11 AM DON stated corporate staff had been doing MDS assessments, but MDS LVN was taking over the responsibility. She stated an inaccurate MDS assessment could absolutely negatively impact the resident. During an interview on 01/15/26 at 11:25 AM ADM stated MDS LVN was responsible for completing MDS assessments. She stated the facility would not be able to provide the correct care to a resident if the MDS assessment was inaccurate. During an interview on 01/15/26 at 11:32 AM MDS LVN stated she began taking over responsibility for MDS assessments on 01/01/26. She stated she had noticed several areas where there appeared to be data entry errors or clerical errors on the MDS assessments for the facility. MDS LVN stated she used the RAI as her policy when completing MDS assessments. MDS LVN stated an inaccurate MDS assessment could negatively impact the resident's care. She stated, It depends on how it is inaccurate and what the error was. MDS LVN stated the MDS assessment directly affected the funding the facility received to provide care to the residents. During an interview on 01/15/26 at 12:08 PM CEO stated the MDS assessments were typically done by different individuals. The social worker has been doing BIMS and depression. The other MDS assessments are assigned to the nurses for example. Now that we have MDS LVN here onsite she will be handling that. When asked if there was a possible negative outcome to a resident of an inaccurate MDS assessment (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CEO stated, That would be concerning. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed the following: . SECTION N: MEDICATIONS Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. N0350: Insulin . Steps for Assessment 1. Review the resident's medication administration records for the 7-day look-back period . 2. Determine if the resident received insulin injections during the look-back period. 4. Count the number of days insulin injections were received . Coding Instructions for N0350A Enter in Item N0350A, the number of days during the 7-day look-back period . that insulin injections were received.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission for 1 (Resident #28) of 13 residents reviewed for care planning. The facility failed to develop a baseline care plan for Resident #28 within 48 hours of his admission on [DATE]. This failure could place newly admitted residents at risk of not receiving effective, person-centered care. Findings Included: Record review of Resident #28's admission record dated 01/14/26 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement), type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), atherosclerotic heart disease of native coronary artery without angina pectoris (fats, cholesterol, and other substances collected on the inner walls of heart arteries without chest pain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and rash and other nonspecific skin eruption. Record review of Resident #28's admission MDS completed on 12/31/25 revealed a BIMS of 7 which indicated severely impaired cognition. Record review of Resident #28's EHR under the Assessments and the Miscellaneous tabs revealed no baseline care plan. Record review of Resident #28's care plan revealed it was initiated/created on 12/31/25 by CEO. During an observation and interview on 01/13/26 at 11:26 PM Resident #28 was seated in his recliner with his legs elevated. He stated staff were trying to find out what was wrong with his legs, why they were red. During an interview on 01/13/26 at 06:58 PM Resident #28's family member stated, He (Resident #28) had a rash that he left the hospital with, and it has gotten worse. They (the facility) just started antibiotics this week hoping that will take care of the issue. During an interview on 01/15/26 at 10:17 AM CNA H stated a resident could be negatively affected by not having a baseline care plan. During an interview on 01/15/26 at 10:20 AM LVN F stated she was not sure who was responsible for completing baseline care plans. She stated a resident could be negatively impacted if staff did not know their (residents') baselines we won't know if they are improving or getting worse. During an interview on 01/15/26 at 10:35 AM RN G stated she was not sure who was responsible for completing baseline care plans. She stated residents were supposed to have a baseline care plan within 24 hours of admission. RN G stated if a resident did not have a baseline care plan direct care staff might not know why the resident was in the facility and how to address that problem. During an interview on 01/15/26 at 10:59 AM ADON stated CEO was responsible for completing baseline care plans. She stated the facility is going to switch that responsibility to nurses. She stated the purpose of a baseline care plan was to get how they (residents) are functioning at the beginning and to get all of their (residents') likes and dislikes and then track changes from there. She stated a resident could be negatively impacted by having no baseline care plan because staff would not know where they started. During an interview on 01/15/26 at 11:11 AM DON stated admitting or charge nurse should be responsible for completing a baseline care plan. She stated, To be honest with you, until just recently it has almost always been [ADON] or [CEO] doing almost all of the assessments. DON stated the purpose of a baseline care plan was, So that you have a basic knowledge when the resident is admitted to the facility of what mobility issues will be needs regarding transfers, diet, psychotropic medication, dental, hearing, vision issues. She stated, It (baseline care plan) should give you the base to begin with and then you build from that. DON stated not having a baseline care plan could negatively impact resident care. During an interview on 01/15/26 at 11:25 AM ADM stated she did not know who was responsible for completing baseline care plans. She stated the baseline care plan was to show staff where the resident was initially and where we (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are headed. ADM stated not having a baseline care plan could negatively impact resident care because staff would not know where the resident started.During an interview on 01/15/26 at 11:32 AM MDS LVN stated the facility was transitioning to having the admitting nurse be responsible for completing the baseline care plan. She stated the purpose of the baseline care plan was to start the resident's plan of care from the day of admission. She stated without a baseline care plan staff would not know the plan of care.During an interview on 01/15/26 at 12:08 PM CEO stated the RN was responsible for completing baseline care plans. She stated, Ideally it would be the RN that is admitting the patient. CEO stated the purpose of the baseline care plan was, To provide basic care as we are getting to know the resident more in depth. It would provide safe care. She stated a possible negative outcome of not having a baseline care plan was, The baseline care plan guides the care for the resident. CEO stated a resident could be negatively affected by not having a baseline care plan.Record review of facility policy titled Care Plans - Baseline and dated December 2016 revealed the following: . A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs . 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #2 and Resident #28) of 13 residents reviewed for comprehensive care plans.1. The facility failed to include Resident #2's antidepressant medication in her care plan.2. The facility failed to include Resident #28's rash in his care plan. These failures could lead to residents not receiving needed care and or symptom monitoring. Findings Included: 1. Record review of Resident #2's admission record dated 01/13/26 revealed an [AGE] year-old female 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 other specified depressive episodes (significant clinical impairment that does not meet standard criteria of a depressive disorder). Record review of Resident #2's annual MDS completed on 10/28/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section N Medications revealed Resident #2 received antidepressant medication. Record review of Resident #2's care plan completed on 11/19/25 revealed no mention of depression or antidepressant medication. The care plan was revised by CEO. Record review of Resident #2's active orders revealed the following orders with corresponding order start dates: 07/02/25 Anti-depressant medication Paroxetine behavior monitoring. 07/02/25 Anti-depressant Paroxetine S/E monitoring. 01/13/26 Paroxetine HCl Oral Tablet 10 MG (Paroxetine HCl) Give 5 mg by mouth one time a day related to OTHER SPECIFIED DEPRESSIVE EPISODES. Record review of Resident #2's GDR tracking report dated 12/26/25 revealed she had been receiving Paroxetine since 03/26/25. During an observation and interview on 01/13/26 at 11:05 AM Resident #2 was in her bed with the head of her bed raised to a seated position. She stated she had no issue with anxiety or depression. 2. Record review of Resident #28's admission record dated 01/14/26 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement), type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), and rash and other nonspecific skin eruption. Record review of Resident #28's admission MDS completed on 12/31/25 revealed a BIMS of 7 which indicated severely impaired cognition. Section M Skin Conditions revealed Resident #28 was having ointments/medications applied to his skin. Record review of Resident #28's care plan revealed it was initiated/created on 12/31/25 by CEO. The care plan did not include any mention of a rash or skin issue. Record review of Resident #28's active orders dated 01/14/26 revealed the following orders with corresponding order start dates: 01/08/26 [Brand name of allergy medication] Oral Tablet 25 MG (Diphenhydramine HCl) Give 1 tablet by mouth at bedtime for rash/itching. 01/10/26 Cephalexin Oral Tablet 500 MG (Cephalexin) Give 1 tablet by mouth three times a day for give TID rash related to RASH AND OHER NONSPECIFIC SKIN ERUPTION. for 7 Days until finished. 12/19/25 Hydrocortisone External Cream 1% (Hydrocortisone (Topical)) Apply to groin every 4 hours as needed for itching. Record review of Resident #28's struck out, completed, and discontinued orders revealed the following order with corresponding start and end date: 12/23/25-12/28/25 Please apply Hydrocortisone cream to affected area on back TID for 5 days until healed three times a day for 5 Days. Record review of Resident #28's progress notes from 12/19/25 to 01/14/25 revealed 55 total entries. The following 13 entries mentioned Resident #28's rash: A note by RN G on 12/22/25 at 04:20 PM Resident . c/o some itchiness to back at end of shift-lotion applied at that time for dry skin. A note by RN G on 12/23/25 at 04:22 PM Resident still c/o itchiness to back today even after shower and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lotion application. [name of physician] notified and new order to apply hydrocortisone tid for 5 days rec'd.A note by LVN E on 12/25/25 at 02:18 PM . Hydrocortisone cream applied to affected area on upper back. Skin to area dry, flaky, and slightly red. [Resident #28] reports that area is itchy but itching improves when cream is applied.A note by LVN F on 12/26/25 at 06:16 PM Resident is on follow for hydrocortisone cream to the back x5 days for rash. Day 3/5, skin to the area is dry and slightly red. After application of cream, resident voices relief.A note by RN J on 12/29/25 at 05:53 AM Continues with improvement to rash to his back, anterior upper thighs, and abdomen. Rash noted less reddened and resident states it not [sic] longer itches. He completed hydrocortisone cream TID yesterday and presents with no adverse reactions and voices relief.A note by LVN E on 12/30/25 at 02:47 PM Resident has completed hydrocortisone cream. No adverse reactions noted. Continues with slight redness to back and ABD but denies itching or discomfort.A note by LVN E on 01/07/26 at 06:40 PM Resident noted with red rash to bilateral forearms and shins as well as on back and abdomen. [physician] notified and telephone order received for Benadryl 25 MG one tablet by mouth QHS.A note by LVN K on 01/08/26 at 04:11 AM Resident f/u new order for [brand name of allergy medication] 25mg PO Q daily. resident cont with red rash to bilateral forearms and shines [sic] .A note by LVN K on 01/09/26 at 04:28 AM Resident f/u new order for [brand name of allergy medication] 25mg PO Q daily. resident cont with red rash to bilateral forearms and shines [sic] .A note by RN G on 01/10/26 at 05:49 PM Resident still with rash to legs, arms and back- states his itching comes and goes but seems to be worse today. family concerned that rash is worse. RN notified [physician] of the rash and worsening of symptoms. New order rec'd for cephalexin 500 mg TID for 7 days .A note by LVN K on 01/11/26 at 04:06 AM Is taking [name of allergy medication] 25mg PO q hs in treatment for the itching and started [brand name of cephalexin] 500mg PO TID x 7 days in treatment for the rash also (initial dosed last night per orders).An infection note by ADON on 01/13/26 at 07:13 AM Type (topical, respiratory, etc) : topical rash Signs and Symptoms (temp, swelling, pain) : rash to BUE,BLE and torso. reports discomfort at times but denies pain. Agrees to notify staff if intervention is needed Diagnostic testing (cultures, labs, type of organism, results, etc) : n/a Treatments (antibiotic, other treatments) : hydrocortisone cream x5 days-treatment complete, [brand name of allergy medication] po at hs, cephalexin 500 mg po tid x7 days Adverse Reactions (hives, respiratory problems) : none noted at this time, resident is able to make needs known and is aware of possible risk An infection note by LVN E on 01/13/26 at 04:02 PM Type (topical, respiratory, etc) : Topical rash Signs and Symptoms (temp, swelling, pain) : Resident continues with slight redness to bilateral elbows and forearms. Skin temperature is normal. Denies itching or discomfort. Temp: 97.9 Diagnostic testing (cultures, labs, type of organism, results, etc) : N/A Treatments (antibiotic, other treatments) : Continues on [brand name of cephalexin] 500 MG TID Adverse Reactions (hives, respiratory problems) : Denies nausea, vomiting, diarrhea, or GI upset.During an observation and interview on 01/13/26 at 11:26 PM Resident #28 was seated in his recliner with his legs elevated. He was wearing shorts, and his lower legs appeared to be red and his lower right leg appeared to be swollen. When asked about his legs, Resident #28 stated he did not know why they were red, but staff were trying to find out why. He stated his legs did not hurt.During an interview and observation on 01/13/26 at 11:58 AM an RN surveyor accompanied this surveyor to look at Resident #28's legs. RN surveyor asked Resident #28 if he had a skin graft on his right leg and he stated he did due to sarcoma.During an interview on 01/13/26 at 06:58 PM Resident #28's family member stated, He (Resident #28) had a rash that he left the hospital with, and it has gotten worse. They (the facility) just started antibiotics this week hoping that will take care of the issue. His right leg is swollen too because years ago he had cancer, and they put a muscle flap there.During an interview on 01/15/26 at 10:17 AM CNA H stated an inaccurate/incomplete care plan could negatively impact the resident's care.During an interview on 01/15/26 at 10:20 AM LVN F stated an inaccurate/incomplete care plan could negatively impact a resident's ability to meet their goals.During an interview on 01/15/26 at 10:35 AM RN G stated staff needed to follow the resident's care plan so a resident could be negatively (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	affected by an inaccurate/incomplete care plan. During an interview on 01/15/26 at 10:59 AM ADON stated CEO was responsible for completing care plans, but the facility was working on transitioning the responsibility to MDS LVN and someone in the corporate office. She stated resident #28's rash should have been included in his care plan. ADON stated Resident #2's antidepressant should have been included in her care plan. She stated residents could be negatively impacted by inaccurate/incomplete care plans because CNAs would not know which symptoms to monitor the residents for, and families would not be informed about the concerns during care plan meetings. During an interview on 01/15/26 at 11:11 AM DON stated CEO was responsible for completing care plans. She stated Resident #28's rash should absolutely be included in his care plan. She stated Resident #2's antidepressant should of course be included in her care plan. DON stated staff are supposed to be using the care plan as a guide to know what to monitor for. So, they [residents] can suffer a lack of monitoring for symptoms if a care plan was inaccurate/incomplete. DON stated the care plan also aides with family notification and participation in resident care. During an interview on 01/15/26 at 11:25 AM ADM stated MDS LVN was responsible for completing care plans. She stated if a resident's care plan was inaccurate/incomplete staff might not provide what is needed for the resident. During an interview on 01/15/26 at 11:32 AM MDS LVN stated CEO was responsible for care plans. She stated Resident #28's rash and Resident #2's antidepressant should have been included in their respective care plans. MDS LVN stated an inaccurate/incomplete care plan could negatively impact resident care because not everybody would know the plan of care for that resident. During an interview on 01/15/26 at 12:08 PM CEO was asked who was responsible for completing care plans and stated, Um, so the opening of a care plan is required by an RN. She stated the RN completed the care plan. CEO stated Resident #28's rash would generally be included in his care plan. She stated, regarding Resident #2's antidepressant, Normally depression should be included in the care plan. CEO stated an inaccurate/incomplete care plan would impact the provision of care. Record review of facility policy titled Care Plans, Comprehensive Person-Centered and dated March 2022 revealed the following: . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, . e. reflects currently recognized standards of practice for problem areas and conditions. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the meals served reflected the nutritional needs of residents in accordance with established national guidelines for all residents when the facility failed to ensure menus were followed by 6 of 6 residents who received pureed meals. A. The facility did not serve onions and peppers to residents with a pureed meal for the lunch meal on 1/13/26 as directed by the menu. These failures could place all residents who received food from the kitchen at risk of decreased meal satisfaction, potential weight loss due to poor meal intake, not having their nutritional needs met, and a decline in health status. Findings included: In an observation and interview on 1/13/26, at 12:40 pm, 6 residents on a pureed diet did not receive onions and peppers on their meal tray. The residents were given carrots instead. In an interview the DM stated the residents with pureed meals had not received onions and peppers from the posted menu because you could not puree them. She stated the residents received carrots instead. This writer reviewed the recipe book and pointed out to the DM there was a recipe for pureed onions and peppers. The DM stated she did not know the recipe had been in the book. She stated she had never tried to puree onions and peppers. The DM stated the consequences of not serving all the menu items to residents on pureed diets could be dissatisfaction with meals and poor nutrition. Record Review of the facility lunch menu for Cycle 11, Week 1 Tuesday 1/13/26, revealed all residents were to be served: Bratwurst Links, [NAME] Noodles, Sauteed onions and peppers, Wheat dinner roll and chocolate cheesecake. Record review of the facility recipes in the facility recipe book revealed a recipe for pureed onions and peppers.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communication diseases and infections for 2 (Resident #1 and Resident #37) of 13 residents reviewed for infection control. -LVN F failed to use proper hand hygiene techniques when preparing and administering medications to Resident #1.-LVN F failed to clean glucometer before and after performing glucose check for Resident #1.-Facility failed to have proper EBP signage on Resident #37 who had a foley catheter. These failures had the potential to affect residents by placing them at risk of contracting, spreading, and/or exposing them to bacterial or viral infections that could lead to the spread of communicable diseases.Findings Included: During an observation on 01/13/2026 at 11:19 AM revealed no signage for enhanced barrier precautions on Resident #37's door. During an interview on 01/13/2026 at 11:19 AM a family member of Resident #37 revealed that the staff have never put on PPE to come in and assist Resident #37 with any care areas. During this interview staff entered the room with PPE on and the family member asked the investigator why are they putting on all that garb? Investigator stated that the staff was supposed to be doing that every time. Family member stated, this was the first time they have ever done it. During an observation on 01/14/2026 at 11:41 AM LVN F did not perform hand hygiene before donning gloves to perform blood glucose check and insulin administration of insulin to Resident #1. LVN F did not clean glucometer before LVN F performed glucose check for Resident #1. During an interview on 01/14/2026 at 2:18 PM LVN F stated a negative outcome for not performing hand hygiene and not cleaning the glucometer could lead to infection for the residents. Interview on 01/15/2026 at 1:44 PM DON stated a negative outcome for not performing HH at the appropriate times and not utilizing PPE for resident on EBPs, could lead to an infection control issue. Record review of policy titled, Enhanced Barrier Precautions, revised March 2024, revealed the following: Policy StatementEnhanced barrier precautions (EBPS) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents.Policy Interpretation and Implementation.3. Examples of high-contact resident cared activities requiring the use of gown and gloves for EBP's include: .g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and .5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.b. Indwelling medical devices include central lines, urinary catheters, . Record review of policy titled, Handwashing/Hand Hygiene, revised October 2023, revealed the following: Policy StatementThis facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Indications for Hand HygieneHand Hygiene is indicated:Immediately before touching a resident;Before performing an aseptic task .After contact with blood, body fluids, or contaminated surfaces;After touching a resident; . Applying and removing GlovesPerform hand hygiene before applying non-sterile gloves. Record review of policy titled, Insulin Administration, revised September 2014, revealed the following: .Steps in the Procedure (insulin Injections via syringe)Wash hands.		