

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: 676461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Country View Living		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Butler Blvd. Dimmitt, TX 79027	
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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings included: Observation of the freezer on 12/9/25 at 9:40 AM revealed the following: 1. (2) plastic bags of okra, no label or date, not in original box. 2. (3) plastic bags of frozen chicken strips, no label or date, not in original box. Observation of the freezer on 12/10/25 at 11:00 am revealed the following: 1. (2) plastic bags of okra, no label or date, not in original box. 2. (3) plastic bags of frozen chicken strips, no label or date, not in original box. In an interview and a walk through with the DM on 12/10/25 at 11:20 AM, the DM stated she expected the kitchen staff to label and date all food items as they were used or taken out of the box. The DM stated she had done spot checks on a weekly basis. When asked who trained the staff on labeling and dating foods, she stated she had trained the staff on labeling and dating the food. The DM stated the consequences of not labeling and dating foods would be food borne illnesses could make residents sick. Record Review of the policy titled Food Storage dated April 2021, documented: Food must be stored in properly covered containers with a date and label identifying the food item. Foods may remain in the [NAME] box as long as content and date are easily visible on the box. Any food removed from the [NAME] box must be labeled and dated.		

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: 676461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Country View Living		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Butler Blvd. Dimmitt, TX 79027	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #38) of 25 residents reviewed for advanced directives. Resident #38 had a DNR in her record that was signed incorrectly by the witnesses. The facility's failure could place residents at risk for not receiving healthcare as per their or their legal representatives' wishes. Findings included: Record review of Resident #38's face sheet printed [DATE] revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), cardiomegaly (enlargement of the heart), and emphysema (a chronic lung condition where the tiny air sacs (alveoli) in the lungs become permanently damaged and enlarged, making it hard to breathe and exhale air). Resident #38 was as a DNR in the section Advance Directives. Resident #38's last MDS was a significant change of condition assessment completed [DATE] listing her with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring setup/clean-up assistance from staff with her activities of daily living. Resident #38's care plan with admission date of [DATE] revealed the following: Problem: Resident has an order for Do Not Resuscitate. Date initiated: [DATE]. Record review of the clinical record for Resident #38 revealed an Order Summary printed [DATE] with the following order: DNR Active - Revision Date: [DATE]. Record review of the clinical record for Resident #38 revealed a DNR dated [DATE] (signed by the physician) with the following: Section - Two Witnesses: Both witness #1 and witness #2 did not date when they signed the document. During an interview on [DATE] at 10:26 AM LVN A (the nurse responsible for Resident #38 this shift) reported that all residents have their code status listed on the front/first page of their electronic chart, and they have a code book on the unit that lists all residents' code status. LVN A reviewed Resident #38 electronic chart and printed code status and stated, Resident #38 is a DNR so we would not do CPR if she had no heartbeat or was not breathing. LVN A reported she would notify management if Resident #38 was to code (found with no heartbeat or was not breathing). When asked to review Resident #38's DNR form listed in Resident #38's electronic record, LVN A reported both witnesses did not date their signatures therefore the DNR form was not valid. LVN A stated, we would start CPR on her if she coded now. LVN A reported if the DNR was not completed correctly it was not considered valid and would affect the resident care, and the facility would not follow the residents' wishes. During an interview on [DATE] at 9:34 AM the DON reported she had been made aware Resident #38 had the date missing from two signatures on her DNR form. The DON reported she and her staff do a complete audit of all DNR's every 6 months and they check for the proper signatures and just missed the dates. The DON reported if the DNR was incorrect then the process will be done wrong for the residents, because you do not have a legal paper. Record review of the facility provided policy titled Advanced Directives updated [DATE], revealed the following: Policy Statement: Advanced Directives will be respected in accordance with state law and facility policy. Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, revised [DATE] revealed the following: The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Country View Living		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Butler Blvd. Dimmitt, TX 79027	
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 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 an assessment accurately reflected a resident's status for 1 (Resident #38) of 15 residents reviewed for accuracy of MDS assessments. -The facility failed to accurately assess Resident #38 for the use of CPAP therapy on her significant change of condition MDS assessment completed 10/07/2025. This failure to accurately assess a resident could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Findings included: Record review of Resident #38's face sheet printed 12/10/2025 revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), obstructive sleep apnea (a sleep disorder that involves cessation or significant decrease in airflow in the presence of breathing effort), congestive heart failure (a chronic condition in which the heart dose not pump blood as well as it should), cardiomegaly (enlargement of the heart), and emphysema (a chronic lung condition where the tiny air sacs (alveoli) in the lungs become permanently damaged and enlarged, making it hard to breathe and exhale air). Resident #38's last MDS was a significant change of condition assessment completed 10/07/2025 listing her with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring setup/clean-up assistance from staff with her activities of daily living. Section O - Special Treatments, Procedures, and Programs G1. Non-invasive Mechanical Ventilator BiPAP/CPAP - Resident #38 was not listed as having this therapy While a Resident. Record review of Resident #38's care plan with admission date of 09/03/2024 revealed the following: Problem: Resident #38 has altered respiratory status/difficulty breathing r/t COPD (a group of lung diseases that block airflow and make it difficult to breath) . CPAP. Date initiated: 9/10/2024. Record review of the clinical record for Resident #38 revealed an Order Summary Report with active orders as of 12/10/2025 with the following order:- BiPAP machine at night and PRN setting: in 12, out 7, rate 12, O2-50% as needed related to DYSPNEA (difficulty breathing), UNSPECIFIED (R06.00) Active 02/07/2025. During an observation and interview on 12/09/2025 at 10:08 AM Resident #38 was observed with a CPAP/BiPAP machine on her bedside table. Resident #38 reported she used the machine nightly and the care and staff were good. During an interview on 12/11/2025 at 9:30 AM MDS Coordinator B reviewed Resident #38 Significant Change of Condition MDS completed 10/07/2025 and stated, We did this (the Significant Change of Condition MDS) because she (Resident #38) came off of hospice and no I did not address her use of CPAP therapy. MDS Coordinator B reported the CPAP therapy should have been addressed, she (MDS Coordinator B) had completed the MDS assessment, and she did not know why the CPAP therapy was missing. MDS Coordinator B reported if the CPAP was not addressed on the MDS then the staff could miss administering the therapy if they review the MDS and the residents might not get their care. MDS Coordinator B reported the facility follows the RAI manual for any policy related issues with the MDS assessment. During an interview on 12/11/2025 at 9:38 AM the DON reported if an MDS was not completed accurately then it was an issue. The DON reported the MDS should accurately reflect the residents' condition or an adverse reaction could occur because the MDS was not correct for the residents care. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023 (RAI Manual) revealed the following: SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS Coding Instructions for Column b. While a ResidentCheck all treatments, procedures, and programs that the resident received or performed afteradmission/entry or reentry to the facility and within the last 14 days. If no treatments.procedures or programs were received by, performed on, or participated in by the residentwithin the last 14 days or since admission/entry or reentry, check Z, None of the above. O0110G1, Non-invasive Mechanical VentilatorCode any type of CPAP or BiPAP respiratory support devices that prevent airways from (continued on next page)		

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: 676461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Country View Living		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Butler Blvd. Dimmitt, TX 79027	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closingby delivering slightly pressurized air through a mask or other device continuously or viaelectronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables theindividual to support their own spontaneous respiration by providing enough pressure whenthe individual inhales to keep their airways open, unlike ventilators that breathe for theindividual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here.This item may be coded if the resident places or removes their own BiPAP/CPAP mask/device.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Country View Living		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Butler Blvd. Dimmitt, TX 79027	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided with such care consistent with professional standards of practice for 1 (Resident #38) of 15 residents reviewed for respiratory care. -Resident #38 was not receiving oxygen at the correct dose. This failure could affect residents by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings included:Record review of Resident #38's face sheet dated 12/10/2025 revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease(airway inflammation and difficulty breathing), Obstructive Sleep Apnea(a sleep disorder that involves cessation or significant decrease in airflow in the presence of breathing effort), Chronic Respiratory failure with hypoxia(low oxygen levels in the blood), dependence on supplemental oxygen(needs extra oxygen to breathe adequately) and need for assistance with personal care. Record review of Resident #38's Significant Change MDS completed 10/07/2025 listed her with a BIMS of 15 indicating her cognition was intact. Resident #38 was listed as receiving oxygen therapy while a resident.Record review of Resident #38's care plan revealed the following revision for oxygen on 10/03/2025 reflected Resident #38 had altered respiratory status related to COPD with an intervention for supplemental oxygen via nasal cannula to maintain saturation at 92% and above, not to exceed 4 liters. Record review of Resident #38's order summary reports revealed the following active orders: Oxygen via nasal cannula at 4L/min continuously related to Chronic Obstructive Pulmonary Disease dated 02/07/2025.Record review of Resident #38's vitals from 09/11/2025 through 12/10/2025 revealed oxygen saturation was above 92% via n/c.During an observation on 12/09/2025 at 10:08 AM Resident #38 was sitting in her wheelchair and was wearing oxygen via nasal cannula at 2L/min Resident #38 stated she wears her oxygen continuously and believed her supplemental oxygen was supposed to be at 2-3lpm. Resident #38 felt she was getting enough oxygen and had no concerns. During an observation on 12/10/2025 at 10:27 AM Resident #38 was in her room watching television while sitting in her wheelchair and was utilizing oxygen at 2L/min. During an interview on 12/10/2025 at 10:35 AM LVN B (the skilled staff member responsible for Resident #38 this shift) checked Resident #38's oxygen and verified that the current dose being administered was 2L/min. LVN B then reviewed Resident #38's physician orders and noted Resident #38 was ordered to receive oxygen at 4L/min. LVN stated Resident #38's orders were wrong, and the orders should be 2L/min and stated the physician and changed it from 4L/min to 2L/min and it must not have been changed in the system. LVN B stated the 2 liters she was receiving was correct and did not believe there was a negative outcome for not following the physician's order. During an interview on 12/10/2025 at 2:17 PM the DON reported that staff were not following the physician's order per the record. The DON stated Resident #38's oxygen order should have been 2-4L/min rather than 4L/min. The DON stated she had contacted the physician, and the order would be changed to reflect 2-4L/min. The DON stated she and the floor nurses were responsible for ensuring correct dosages were administered and acknowledged that because the physician's order stated 4L/min, the discrepancy would have been addressed. The DON stated that failure to administer the correct oxygen dose could have resulted in harm to the resident. Record review of the facility provided policy titled, Oxygen Administration updated April 2025, reflected the following: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.		