

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: 455641	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Palo Duro Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 405 S Collins St Claude, TX 79019	
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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on interview, observations and record review the facility failed to provide, based on the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 12 residents reviewed for activities. A. The facility failed to follow the activity calendar for August. B. The facility activity calendar for August failed to incorporate physical activities and interaction in the community into its activity programs. These failures could place residents at risk of reduced quality of life and boredom in life by not receiving activities to meet their individual needs. Findings included: In an observation of the facility activity room and main facility day area on 8/18/25 from 8:45 am to 11:00 am revealed there were no activities occurring in the facility. Residents were observed sitting around the day area with no activity supplies out. There was one tv on in a further corner of the day area. Residents were not sitting in front of the tv. The activity of Current Events did not occur. In an observation of resident rooms there were no activity calendars posted. In an observation of the facility on 8/18/25 from 1:30 pm to 2:30 pm revealed there were no activities occurring in the facility. The activity of crafts was not done. In a confidential interview on 8/18/25 at 9:00 am, one resident stated he was bored all the time and there was nothing to do in the facility. He stated he would like to go outside when he wanted to, but the facility would not let him. He stated he would like to exercise in the mornings, but it was not offered. He stated he did not like Bingo. He stated he liked golf. He stated the facility does not take residents out of the facility and he would like to go on a van ride sometimes. He stated the activity calendar was not followed. In a confidential interview on 8/18/25 at 9:15 am, one resident stated he did not like Bingo and would like to exercise in the mornings. He stated the residents do not ever get to go anywhere. He stated he would love to go outside but was told they could not stay outside without staff. He stated the facility did not leave any activity materials out for the residents to do. He stated he was just bored all the time. He stated he liked working with his hands and he used to fix things. He stated he liked working on cars. He stated the facility does not ever take the residents on outings out and he would like to go anywhere out of the facility. He stated the activity calendar was not followed. In a confidential interview on 8/19/25 at 3:00 pm, one resident stated she had not gone to any activities and did not know what was offered. She stated she did not go to Bingo today because no one had told her it was available or had come to get her. She stated she did not know it was offered. She stated she did not play games, but she did go to the facility church on Sunday. She stated she would like to get out of the facility and do something like eating, shopping or just ride around. In an observation on 8/19/25 from 9:30 am to 10:30 am revealed there were no activities occurring. Residents were sitting around the day area with no cards or activity supplies. In an observation of resident rooms there were no activity calendars posted. In an observation on 8/20/25 from 8:15 am to 8:40 am revealed there were no activities occurring. Residents were sitting around the day area with no cards or activity supplies. In an observation of resident rooms there were no activity calendars posted. In an interview on 8/20/25 at 11:30 am, the AD stated she had completed her training for the AD position in May 2025. She stated she was still trying to figure out (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what to do. She stated she did not work weekends. The AD stated she had tried to follow the calendar the month of August but had not been able to due to being short of staff. She stated she also had to do CNA and had to work in the kitchen as well as the AD duties. She stated the activity calendar had not been followed on Monday 8/18/25. She stated she did not have any activities on Monday 8/18/25. The AD stated the only activity completed on Tuesday 8/19/25 was Bingo. The AD stated she did room visits for 4 residents who did not get out of bed. She stated she did not document the visits. When asked what activities she did with the residents who did not get out of bed, she stated she talked to them for 15 minutes. She stated she always had snacks to pass out to the residents. She stated one day she and the RCP made chocolate dipped cookies and chocolate covered strawberries and passed them out to the residents. When asked why the other residents did not participate in the cooking, she stated she did not think about the other residents doing a cooking activity. She stated she was not sure what the residents could do or not do. The AD stated she did not know she could get residents up for an activity if they were lying in bed. When asked what activities she had for residents with behaviors she stated she walked around the facility with Resident sometimes. She stated Resident blank would play bingo and liked to color. The AD stated she had not left activity materials out on the weekends and when she was not available. She stated her doors and cabinets were always required to be locked, and her door was shut when she was not in the facility. She stated the staff could open her door when she was not in the facility. She stated activity supplies were locked in her cabinets. The AD stated she was aware many of the residents wanted to go sit out on the patio but stated they were not allowed to stay outside. She stated the residents who smoked like to stay out on the patio as long as they could, but staff were required to have the residents come back into the facility when smoke break was completed so staff could continue working. In a confidential interview on 8/19/25 at 12:30 pm, one resident stated she does not participate in the activities because she could not get up without assistance and needed assistance to go to the activity. She further stated no one had come to get her to take her to the activities. She stated she thought it was boring to lay in bed all day. In an observation of the facility on 8/19/25 from 1:15 pm to 2:15 pm, one resident was observed wandering the facility hallways. Another resident was in the hallway going up and down the halls. Several residents were sitting in the day area with no activity materials out. In a confidential interview on 8/20/25 one resident stated the AD did not follow the calendar because she had to work the floor and the kitchen. She stated she had no interest in playing card games or having her nails done. She stated the AD does serve snacks a lot. She stated one day she and the AD made chocolate dipped cookies and strawberries for the residents and passed them out. She stated it was just the AD and herself that did the activity. She stated none of the other residents were asked to do the activity and she did not know why. She stated there were no activities on the weekends except a church service. In a confidential interview on 8/20/25 at 1:30 pm, two staff members stated there were no activities on weekends except church on Saturday am and on Sunday am. Both staff members stated there were no activities done by staff on weekends and there were no supplies left out for the staff to provide residents. Both staff stated they could not get into the activity directors' room and that all activity supplies were locked up. Both stated they did not know where the activity supplies were in the activity cabinets. Both staff members also stated the activities during the week were very limited and were usually not done. Both staff stated there were no activities for the residents with behaviors. In an interview on 8/20/25 at 2:30 pm, the ADM stated he expected the activity calendar to be followed. He stated the consequences of not providing activities to residents could be boredom. Record review of the facility Activity calendar for the month of August 2025, revealed the following. Saturday August 16, 20251:30 pm Resident Choice Sunday August 17, 20251:30 pm Resident Choice Monday 8/18/259:30 am Current Affairs1:30 pm Crafts Tuesday, August 19, 20259:30am Dominoes2:30 pm Bingo Record review of the facility employee job description titled, Activity Director dated 2023, revealed the activity director is responsible for directing developing implementing the activities program designed to meet the social, psychosocial and therapeutic needs of the resident. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directing the activity program includes scheduling and implementing recreational, educational, cultural and arts and crafts programs inside and outside the facility.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for the months of April 2025, May 2025, June 2025, July 2025 and August 2025 .for weekend RN coverage. A. The facility failed to ensure they had RN coverage 8 hours a day, 7 days a week for the following days: April 202504/13/25, 04/19/25, 04/20/25 May 202505/03/25, 05/10/25, 05/11/25, 05/17/25, 05/18/25, 05/24/25, 05/25/25 June 202506/1/25, 06/7/25, 06/08/25, 06/14/25, 06/15/25, 06/22/25 July,2025 07/05/25, 07/6/24, 07/12/25,07/13/25, 07/19/25, 07/20/25, 07/26/25, 07/27/25 August,202508/02/25, 08/03/24, 08/09/25, 8/10/25, 08/16/25 and 08/17/25 This failure could place residents at risk for inconsistency in care and services. Findings included: Record review of the facility's undated employee roster revealed there were two RNs employed at the facility in April. Record Review of time sheets provided by the BOM for the time from 04/01/25-08/18/25 revealed the following dates did not have RN coverage for at least 8 hours a day for the following days: April 202504/13/25, 04/19/25, 04/20/25 May 202505/03/25, 05/10/25, 05/11/25, 05/17/25, 05/18/25, 05/24/25, 05/25/25 June 202506/1/25, 06/7/25, 06/08/25, 06/14/25, 06/15/25, 06/22/25 July,2025 07/05/25, 07/6/24, 07/12/25,07/13/25, 07/19/25, 07/20/25, 07/26/25, 07/27/25 August,202508/02/25, 08/03/24, 08/09/25, 8/10/25, 08/16/25 and 08/17/25 In an interview on 08/19/25 at 9:45 am, the BOM stated the facility had not had RN coverage on most weekends since April. She stated the DON had just given her a stack of time sheets she had just filled out for weekends from April to the present. The BOM stated this was unethical and she had an issue putting the time into the system. The BOM stated the DON was not in the building on those days. In a confidential interview on 08/19/25 at 10:10 am, one staff member stated the DON had never worked in the building on weekends for RN coverage. She stated there had not been RN coverage in the building since April. She stated she had called the DON one day on a weekend when she needed assistance, and the DON stated she was not able to go to the facility on that date. In a confidential interview on 08/19/25 at 10:21 am, one staff member stated she had worked weekends and did not have an RN working with her for several months. She stated she had called the DON one weekend for assistance and the DON had told her to call the ADON who was an LVN. She stated the DON had not come into the facility when there had been an issue. In a confidential interview on 08/19/25 at 10:30 am, one CNA stated she usually worked weekends and had never seen the DON in the building on a weekend. The CNA stated there had not been an RN working on weekends since April. In a confidential interview on 08/19/25 at 10:55 am, one RN stated she no longer worked at the facility and did not know why she was still listed on the employee roster. She stated she had not worked in the facility since April. She stated when she worked at the facility the DON had not been in the building on weekends. In an interview on 08/20/25 at 8:15 am, RN F stated she works at another medical facility during the week. She stated she had not worked in the facility since April. She stated she had not seen the DON in the building on weekends. In an interview on 08/20/25 at 2:00 pm, the DON stated she was responsible for ensuring RN coverage for the facility. She stated she had been aware the facility had not had adequate RN coverage for the weekends since April. She stated she and the ADON, who was an LVN, took turns being on call during the weekend. The DON stated the ADON and she alternated weekends. The DON stated she had not physically come to the facility on the weekends when she was on call, but she had been available by phone. When asked if there had been a situation where she needed to be in the facility she stated there had not been. The DON stated consequences of not having an RN in the facility would be the potential for improper care for residents. During an interview on 08/13/24 at 1:55 pm, the Administrator stated he was aware the facility had not had RN coverage on weekends. He stated there had always been an LVN in the building and the DON and ADON were available by phone if needed. The ADM stated there were no (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consequences for not having a DON in the building as she had been available by phone. Record review of the facility policy titled Nursing Services and Sufficient Staff dated 9/1/23 revealed the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity and care for each resident in a manner and in an environment, that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 12 residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1's catheter drainage bag was covered and urine in the bag was not visually exposed. This failure could place residents at risk of feeling uncomfortable and disrespected and could decrease residents' self-esteem and/or quality of life. Findings included: Record review of Resident #1's face sheet, dated 08/18/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included, but not limited to, paraplegia (a type of paralysis that affects lower half of the body), muscle weakness, chronic pain syndrome and other lack of coordination. Record review of Resident #1's admission MDS dated [DATE] reflected the following: Section C-Cognitive Patterns: Resident #1 had a BIMS of 15 out of 15, which indicated his cognition was intact. Section H-Bladder and Bowel: Resident #1 had an indwelling catheter. Record review of Resident #1's physician orders, dated 07/02/2025, reflected provide catheter care every shift; Foley catheter privacy bag in place. Record review of Resident #1's care plan dated 07/07/2025 reflected resident had a long-term indwelling foley catheterization with intervention to change catheter and drainage bag per facility protocol or as ordered by provider. During an interview and observation on 08/18/2025 at 10:01 AM, revealed Resident #1's catheter bag had no protective cover and hanging from the resident's wheelchair. There was a small amount of amber liquid noted in the bag. Resident #1 stated he had been in the facility for approximately a month and had not received a privacy cover for his catheter bag, he stated he would like a privacy bag but was not offered one. During an observation on 08/18/2025 at 12:00 PM, Resident #1 was in his wheelchair in the dining area getting a drink, his catheter bag was hanging from his wheelchair, it did not have a privacy cover over the bag, and a small amount of amber liquid noted in bag. During an observation on 08/19/2025 at 1:45 PM, Resident #1 was exiting his room in his wheelchair with his catheter bag hanging from the middle of his wheelchair, no privacy cover noted on bag. During an interview on 08/20/2025 at 8:45 AM, the ADON stated that all nursing staff were responsible for making sure catheter bags were covered because it could be dignity issue for the resident and could make other residents uncomfortable. The ADON said nursing staff including she and the DON were responsible for ensuring privacy covers were in place. During an interview on 08/20/2025 at 8:47 AM, the MDS Coord, an LVN, stated that all nursing staff were responsible for making sure catheter bags were covered because it was a dignity issue for both the resident with the catheter and other residents that would be objected to seeing the uncovered bag. During an interview on 08/20/2025 at 8:50 AM, the ADM stated that all nursing staff were responsible for making sure catheter bags were covered because it could be dignity issue for both the resident that had the catheter bag as well as the residents around him. The ADM stated he was ultimately responsible to ensure his nursing staff were educating the staff as well as the resident on the importance of privacy bags. During an interview on 8/20/2025 at 9:00 AM, CNA B stated CNAs were responsible for ensuring privacy bags were on the catheter bag but then said all nursing staff were responsible for guaranteeing privacy bags were put on catheter bags and not having a privacy bag was disrespectful to the resident. During an interview on 08/20/2025 at 11:15 AM, the DON stated it was her responsibility to ensure her nursing staff maintained resident dignity and compliance by placing privacy bags on catheter bags. The DON stated the failure to use a privacy cover was a dignity issue, as it was a resident rights issue to privacy. Record review of the facility-provided policy titled, Catheter Care dated 09/01/2023 reflected the following: Privacy bags will be available and catheter drainage bags will be covered at all times when in use. Record review of the (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility-provided policy title, Resident Rights dated 09/01/2023 reflected the following: The resident has the right to a dignified existence.		

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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 an assessment accurately reflected resident's status for 2 (Resident #3 and #30) of 12 residents reviewed for accuracy of MDS assessments. -The facility failed to accurately assess Resident #3 for the use of oxygen on her 06/08/25 annual MDS. -The facility failed to accurately assess Resident #30 for weight loss on his 07/24/25 quarterly MDS. This failure could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Findings included: Resident #3Record review of Resident #3's face sheet printed 08/18/25 revealed she was a [AGE] year-old female resident admitted to the facility originally on 08/10/22 and readmitted on [DATE] with diagnoses to include congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all throughout the body), and history of venous thrombosis and embolism (refers to a formation of blood clots in the veins, and the potential for these clots to travel to other parts of the body). Record review of Resident #3's last MDS was an annual assessment completed 06/08/25 listing her with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring set-up/clean-up assistance with all her activities of daily living. Section O - Special Treatments, Procedures, and Programs: Resident #3 was not listed for Oxygen Therapy while a resident. Record review of Resident #3's care plan with admission date of 07/20/24 revealed the following: Focus: Resident requires supplemental oxygen to maintain adequate oxygenation due to chronic or acute respiratory condition, placing them at risk for impaired gas exchange, skin breakdown, and safety hazards. Oxygen @ 2L NC Date Initiated: 07/03/2025 Record review of the clinical record for Resident #3 revealed an Order Summary Report with active orders as of 08/19/25 with the following order:- Oxygen at 2 l/m per nasal cannula PRN for SOB/hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissue) every shift for hypoxia Verbal Active 12/07/2024. Record review of the clinical record for Resident #3 revealed a Treatment Administration Record with treatments from 05/01/25 to 05/31/25 and 06/01/25 to 06/30/25 with the following: Oxygen at 2L/min per nasal cannula PRN for SOB/hypoxia every shift for hypoxia. - Oxygen was documented as administered daily 05/26/25 to 05/31/25 and 06/01/25 to 06/08/25 when the annual MDS was started. Oxygen was administered daily for the 14 day look back period required to complete the annual MDS assessment for Oxygen therapy. During an observation on 08/18/2025 at 09:55 AM Resident #3 was in her bed with oxygen on via nasal cannula. During an observation on 08/18/2025 at 11:19 AM Resident #3 continued to be asleep with her oxygen on via nasal cannula. During an observation on 08/18/2025 at 12:18 PM Resident #3 was sleeping in her bed without her oxygen on. Resident #3 awoke to knocking and reported that she does not need her oxygen all the time. Resident #3 stated that she had removed her oxygen to go to the bathroom at 11:15 AM. During an interview on 08/20/2025 at 09:38 AM Per interview the MDS Coordinator reviewed Resident #3 records and verified that Resident #3 did require the use of oxygen, and that oxygen use should have been addressed on Resident #3's annual MDS assessment complete 06/08/25. The MDS Coordinator reported that she just missed it on the treatment administration record when she misunderstood the O2 saturation readings. The MDS Coordinator reported a negative outcome from not completing the MDS assessment accurately could reflect in the resident missing an illness, an injury, or a treatment on the MDS that could affect the facility's reimbursement which could eventually affect the care that could be provided to the residents. Resident #30Record review of Resident #30's face sheet printed 08/18/25 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include traumatic brain injury (an injury to the brain caused by an external force, such as a blow to the head or an object piercing the skull), intermittent explosive disorder (a behavioral disorder characterized by (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explosive outburst of anger and/or violence, often to the point of rage that are disproportionate to the situation at hand), dementia (a group of thinking and social symptoms that interferes with daily functioning), muscle wasting (the loss of muscle mass and strength due to disease, injury, or lack of use), psychotic disorder with hallucinations (characterized by a person experiencing false sensory perceptions meaning they see, hear, feel, smell, or state, things that are not actually happening), and person injures in unspecified motor-vehicle accident. Record review of Resident #30's last MDS was a quarterly assessment completed 07/24/25 listing him with a BIMS of 00 indicating he was severely cognitively impaired, and he had a functionality of being dependent on staff for all his activities of daily living. Section K - K0300 Weight Loss: Loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Resident #30 is marked 0 for No or Unknown. Record review of Resident #30's care plan with admission date of 12/01/17 revealed the following: Focus: I have the potential for a nutritional problem R/T Diet restriction, total dependence for feeding, and dysphagia. Recent significant weight loss with a 27-pound loss since January 2025. Date Initiated: 12/15/2020 Revision on: 07/07/2025 Interventions/Tasks Monitor and report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date Initiated: 12/15/2020 Revision on: 04/01/2025 Record review of the clinical record for Resident #30 revealed a Weight Summary Report with the following weights: 07/22/2025 - 101.0 lbs. 06/22/2025 - 113.0 lbs. (This is a -10.62% weight loss in a 1-month period prior to the 07/24/25 quarterly MDS assessment.) 07/22/2025 - 101.0 lbs. 01/02/2025 - 129.0 lbs. (This is a -21.71% weight loss in a 6-month period prior to the 07/24/25 quarterly MDS assessment.) During an observation on 08/18/2025 at 09:42 AM Resident #30 was up in the main lobby in a specialized wheelchair with 5 resident presents. He appeared in good condition, was alert but unable to respond appropriately to questions. Resident #30 just smiled but did not respond verbally. During an interview on 08/20/2025 at 09:48 AM the MDS Coordinator reviewed Resident #30 records and verified Resident #30 did have weight loss that should have been addressed on his 07/24/2025 quarterly MDS assessment. The MDS Coordinator reported she did not have his weight in the required time because it was not documented in Resident #30's chart by staff in a timely manner prior to the 07/24/2025 quarterly MDS assessment. The MDS Coordinator verified she documented in the 07/24/2025 MDS assessment Resident #30 weighed 101lbs on 07/22/25 and 113lbs on 06/22/25 which was a greater than 5% weight loss and on 01/02/25 Resident #30 weighed 129lbs which was a greater than 10% weight loss. The MDS Coordinator reported Resident #30's 07/24/2025 MDS was inaccurate. The MDS Coordinator reported a negative outcome from not completing the MDS assessment accurately could reflect in the resident missing an illness, an injury, or a treatment which could affect the facility's reimbursement and could eventually affect the care that could be provided to the residents. The MDS Coordinator reported the facility [NAME] the RAI manual to complete all MDS assessments. During an interview on 08/20/2025 at 3:47 PM the DON reported she did not feel the missing assessments for Resident #3 and #30 on their MDS's was an issue but she would get with her MDS Coordinator and make sure it gets addressed. The DON reported that if the facility did not bring attention to these issues, then it could become an issue and a resident's condition such as Resident #3's respiratory condition or Resident #30's weight loss would not be addressed and then it could affect that condition such as Resident #30 could just waste away. 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 Resident Check all treatments, procedures, and programs that the resident received or performed after admission/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 resident within the last 14 days or since admission/entry or reentry, check Z, None of the above. O0110C1, Oxygen therapy Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455641	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Palo Duro Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 405 S Collins St Claude, TX 79019	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AirwayPressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaricoxygen for wound therapy in this item. This item may be coded if the resident places or removes their own oxygen mask, cannula. 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 K: SWALLOWING/NUTRITIONAL STATUS Coding Instructions Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as 1. Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or [NAME] the last 180 days, and the weight loss was not planned and prescribed by a physician.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 12 residents (Resident # 6) reviewed for trauma-informed care. The facility did not ensure Resident #6 had a trauma screening that identified possible triggers when Resident #6 had a history of trauma. This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. Findings included: Record review of the face sheet, dated 08/19/2025, indicated Resident #6 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (a mental health condition that can develop in people who experience or witness a traumatic event), and anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). Record review of the quarterly MDS assessment, dated 06/27/2025, revealed Resident #6 had a BIMS of 07, which indicated severe cognitive impairment. The MDS Assessment revealed Resident #6 had PTSD as an active diagnosis. Record review of the comprehensive care plan, latest revision on 07/02/2025, had no documentation of Resident #6's post-traumatic stress disorder or any interventions/ triggers related to Resident #6's PTSD. Record review of Assessments in Resident #6's clinical file dated 08/20/2025 revealed no Trauma Informed Care Assessment. During an attempted interview and observation on 08/19/2025 at 6:56 AM, Resident #6 was in his wheelchair, he was ambulating to the soda machine. Another resident in the facility yelled at him across the common area that he did not need a drink or need help getting a drink. Observation of Resident #6 revealed he was getting money out of his wallet to buy a drink. The DON approached him and asked if she could help, Resident #6 yanked the money back and stated he did not need help. After a few minutes the DON was able to help Resident #6 get his money and help him get his drink. Resident #6 declined to answer if he was upset about the other resident yelling at him. During an interview and observation on 08/19/2025 at 2:00 PM, Resident #6 was in his room, he was sitting on his bed, he stated he had PTSD from the war. Resident #6 did not want to discuss his diagnosis or what led to his PTSD. During an interview and observation on 08/20/2025 at 8:45 AM, the ADON stated trauma assessments were to be done at admission and the SW or nurse on duty was responsible for ensuring the assessments were completed. The ADON stated the interventions should be documented in the care plan. The ADON was observed looking through Resident #6's clinical file and stated she could not find that an Assessment had been completed. The ADON said a possible negative outcome for not having the assessment would be staff would not know what the resident's triggers were and the resident could be retraumatized. During an interview on 08/20/25at 8:47 AM, the MDS Coord stated a Trauma Assessment should be documented in the resident's clinical file including the care plan and stated a possible negative outcome for not having documentation would be a resident could be triggered by an event. During an interview on 08/20/2025 at 8:50 AM, the ADM stated he was ultimately responsible for ensuring assessment were completed but the social worker and nursing staff should be doing the assessment, the ADM said a possible negative outcome would be the resident could be traumatized if staff were not aware of his triggers. During an interview on 08/20/2025 at 10:02 AM, the SW stated she would be the one responsible for the Trauma Assessments but was not aware of what a Trauma Assessment form was, stated she thought the triggers would be discussed in care plan meetings and put in the care plan or progress notes. The SW stated the diagnosis of PTSD and the interventions related to the diagnosis should be in the resident's care plan and his history of trauma she have been discussed in care plan meetings. Not assessing a resident and applying the interventions in the care plan could cause a resident to withdraw and become isolated. During an interview on 08/20/2025 at 11:15 AM, the DON stated she expected (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trauma assessments to be done on admission or anytime the need arose. The DON stated the trauma assessment was the social services responsibility. The DON stated the trauma assessment was important because it allowed the staff to give the resident the best possible care. The DON stated interventions should be in the resident's care plan and stated the failure of not having a trauma assessment could cause the resident to be retraumatized. Regarding the incident with Resident #6 and the soda machine, the DON said she did not know if the other resident yelling across the common area triggered Resident #6 and stated she would be working on identifying the needs for Resident #6 relating to his PTSD. During an interview on 08/20/2025 at 11:30 AM, the Corp RN stated trauma assessments were to be done on admission and documented in the resident's clinical file. The SW or nursing staff were responsible for ensuring the assessments were completed. The Corp RN stated he could not find that an assessment had been completed on Resident #6 and stated it should have been due to his diagnosis of PTSD. The Corp RN said a possible negative outcome for not having the assessment would be staff would not recognize what triggered the resident and it could cause a lapse in care. During an interview on 08/20/2025 at 1:30 PM, LVN D stated she was not aware of what a Trauma informed Assessment was but stated with regards to a diagnosis of PTSD, staff should be aware of the diagnosis so they could identify what may trigger that resident so he could have the best possible care. Record review of the facility's policy titled Trauma-Informed Care revised on 4/25/25, indicated: The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument, admission Assessment, the history and physical, the social history/assessment and others. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which retraumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan.		

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that 1 (CNA A) of 5 CNA's were certified in accordance with applicable state laws. CNA A worked 7 days in the facility with an expired CNA certification. The deficient practice of failing to ensure employee certifications could affect all residents by exposing them to inadequate care resulting in deterioration of their conditions. Findings included: During a record review completed on [DATE] at 11:02 AM CNA A was noted to have a CNA certification that expired on [DATE]. During a record review of the employee time sheet for CNA A, CNA A was noted to have worked in the facility as a CNA on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] for a total of 7 days prior to this survey entry. During an interview on [DATE] at 1:00 PM Per interview the BOM verified CNA A's certification had expired on [DATE] and CNA A worked in the facility on the night shift on 08/08, 08/09, 08/10, 08/11, 08/12, 08/13, 08/14, and [DATE]. The BOM reported that she notified the DON (the CNA's supervisor) by email on [DATE] that the CNA's certification would expire on [DATE] and it would need to be renewed and upon notification it becomes the supervisor's responsibility to ensure the certification is renewed. The BOM reported that she verifies each employee's license/certification when they are hired and then she enters the information in a tracking log that she checks each month and notified the responsible supervisor. The BOM reported that the facility has no specific policy concerning verifying a staff members license/certification status. (Record review revealed an email was sent on [DATE] at 10:16 AM from the BOM to the DON advising that CNA A's certification would expire on [DATE].) During an interview on [DATE] at 1:28 PM the DON reported she was aware that CNA A's certification was expired. The DON reported that she was planning on moving CNA A to a nurse aide status until CNA A was able to renew her license but she (the DON) did not get that done. The DON reported she had contacted CNA A, and that CNA A reported that she was unaware that her certification had expired. The DON stated if an employee was to work with an expired certification and anything were to happen while their certification was expired it would be an issue that could affect residents by having a non-licensed person harming them. The DON reported the facility did not have a policy for checking a staff members license but we are all currently working on one. During an interview on [DATE] at 2:22 PM CNA A reported that she just found out from the facility that her CNA certification had expired and that she would not be allowed back to work until it was renewed, which she was working on right now. CNA A reported that with the new state system she was not notified that her license was about to expire and that in the past she would have been emailed when the time was due to renew, this was why she was unaware of the certification expiring. CNA A did not feel the expired certification would affect the residents in any way since she had been a CNA for a while.		