STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675016	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Plains Nursing and Rehabilitation	315 E 19th Dumas, TX 79029

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 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 interview, observation, and record review, the facility failed to ensure all residents were treated with respect and dignity for 1 of 3 residents (Resident #1) reviewed for dignity. The facility failed to ensure LVN A provided privacy during wound care for Resident #1. This failure placed all residents at risk of psychosocial harm due to a diminished quality of life. Finding included: Record review of Resident #1's face sheet undated revealed a [AGE] year-old male with an admission date of 05/30/2024 with the following diagnoses: peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), open wound, cognitive communication deficit (difficulties in communication), traumatic brain injury. Record review of Resident #1's Comprehensive MDS dated [DATE] revealed a BIMS score of 11 which indicated resident's cognition was moderately impaired. During an observation of wound care on 05/28/25 at 03:24 PM, LVN B closed the door, pulled middle curtain and closed window blind. Resident #1 did not have a curtain at foot of bed. Resident #1's roommate was in room during wound care . Resident # 1 was lying in bed with right backside of upper thigh exposed during wound care. During an interview on 05/29/25 at 01:45 PM with LVN B, she stated during wound care they always just close the middle curtain, door, and window blind. She stated she does not know why there was no end privacy curtain. She stated having no curtain at the end of resident's bed would violate resident privacy if the roommate went to the bathroom or someone came in the room. She stated Resident #1's roommate was independent in his wheelchair. She stated Resident #1 was dependent on staff and wound care and ADLs was done in the resident bed. She stated she had been trained to provide resident privacy during wound care. During an interview on 05/29/25 at 02:19 with LVN B, she stated housekeeping had taken down privacy curtains to wash and forgot to put back up. During an interview on 05/29/25 at 03:00 PM with Resident #1, when asked how he would feel if someone saw him during wound care Resident #1 laughed. When asked if he would be embarrassed if someone saw him during wound care Resident #1 stated yes. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/25 at 08:48 AM with the DON, she stated privacy should be provided during resident care. She stated all curtains should be pulled. She stated she was not aware of any reason the resident would not have a curtain at the foot of his bed. She stated housekeeping had taken the curtain down to wash and did not put it back up. She stated rooms were monitored daily during champion rounds. She stated champion rounds was department heads make room rounds at least once a day. She stated all staff had been trained to provided resident privacy while providing care. She stated resident was a total care. She stated the potential negative outcome could be resident being exposed to roommate and visitors causing embarrassment. During an interview on 05/30/25 at 09:00 AM with the ADM, he stated privacy should be provided during resident care. He stated the curtain at the foot of Resident #1's bed was taken down by laundry to wash and was not replaced. He stated HSK was responsible for washing and replacing the privacy curtains in resident rooms. He stated rooms were monitored daily during champion rounds. He stated he was not aware Resident #1 did not have a privacy curtain at the foot of his bed. He stated staff were trained on resident privacy during care. He stated the potential negative outcome could cause the resident embarrassment and it was a dignity issue. During an interview on 05/30/25 at 10:45 AM with HSK Supervisor, she stated HSK was responsible to washing and putting the privacy curtains up. She stated resident rooms were monitored daily during champion rounds and she was not aware Resident #1 did not have a privacy curtain at foot of bed. She stated Resident #1 curtain was taken down to wash and was not replaced. She stated the curtain should be replaced when taken down for laundry. She stated there was extra privacy curtains in laundry. She stated privacy curtains were used to provide resident privacy. She stated the potential negative outcome could cause the resident to not have privacy during care . Record review of the facility policy titled Resident Rights dated revised 11/28/2016 revealed the following: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy . Privacy and confidentiality - the resident has a right to personal privacy and confidentiality of his or her personal and medical records. 1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with an accurate PASRR Level I for 2 of 15 residents (Resident #7 and Resident #23) reviewed for PASRR screening, in that: 1. Resident #7 did not have an accurate and updated PASRR Level 1 assessment reflecting a diagnosis of mental illness. 2. Resident #23 did not have an accurate and updated PASRR Level 1 assessment reflecting a diagnosis of mental illness. These failures could place residents, with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation, at risk for not receiving care and services to meet their needs. The findings included: Resident #7 Record review of Resident #7's electronic face sheet dated 05/29/2025 revealed an [AGE] year-old female initially admitted to the facility on [DATE]. The face sheet included the following diagnoses: Heart Failure, Unspecified, Primary, with an onset date of 03/07/2024. Psychotic disorder with delusions due to known psychological condition (severe mental health disorder that cause abnormal thinking and perceptions), Secondary 2, with an onset date of 04/23/2024. Generalized Anxiety Disorder (excessive, ongoing worry that is hard to control), Secondary, with an onset date of 03/07/2024. Major Depressive Disorder Recurrent, Severe without Psychotic Features (a mood disorder that causes a persistent feeling of sadness and loss of interest), Secondary, with an onset date of 03/07/2024. Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance (loss of mental functions severe enough to affect daily life and activities) Secondary, with an onset date of 03/07/2024. Alzheimer's disease with late onset (common dementia type that develops after age [AGE]), Secondary, with an onset date of 03/07/2024. The document did not indicate Resident #7 had a primary diagnosis of dementia. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's Quarterly MDS dated [DATE], revealed under section I, Resident #7 had an active diagnosis of Psychotic Disorder. Additionally, under Section C Cognitive Patterns, Resident #7's MDS revealed a BIMS of 10, indicating the resident was moderately, cognitively impaired. Record review of Resident #7's care plan with a last Care Plan review date of 05/09/2025, under Diagnoses, indicated Resident #7 had a diagnosis of Psychotic Disorder with Delusions Due to Known Psychological Condition and Major Depressive Disorder. Additionally, the care plan included a focus area that began on 03/07/2024 which stated, The resident has mood problem r/t Disease Process of Depression., with a goal that was revised on 03/21/2025 which stated, The resident will have improved mood state happier, calmer appearance, no s/sx of depression, anxiety, or sadness through the review date., with the Interventions/Tasks that included the following: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 03/07/2024; Assist the resident to identify strengths, positive coping skills and reinforce these. Date Initiated: 03/07/2024; Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 03/07/2024; Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. Date Initiated: 03/07/2024; Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. Date Initiated: 03/07/2024; Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. Date Initiated: 03/07/2024; Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols. Record review of Resident #7's physician's Order Summary as of 05/29/2025 revealed under Diagnoses, Major Depressive Disorder Recurrent, Severe Without Psychotic Features and unspecified Psychotic Disorder with Delusions Due to Known Psychological Condition. Resident #7 was prescribed buPROPion HCl ER (hydrochloride extended-release) (XL) Oral Tablet Extended Release 24 Hour 150 MG (Bupropion HCl) 1 tablet by mouth one time a day related to Major Depressive Disorder Recurrent, Severe Without Psychotic Features, risperiDONE Oral Tablet 1 MG (Risperidone) 1 tablet by mouth at bedtime related to Major Depressive Disorder Recurrent, Severe Without Psychotic Features and Generalized Anxiety Disorder, and Sertraline HCl (hydrochloride) Oral Capsule 200 MG (Sertraline HCl) 1 capsule by mouth one time a day related to Major Depressive Disorder Recurrent, Severe Without Psychotic Features. Record review of Resident #7's Preadmission Screening and Resident Review (PASRR) Level One (PL1) form dated 03/07/2024 revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. There were no additional PL1 screenings provided by the facility for Resident #7. There were no additional documents provided to suggest Resident #7 had a completed PASRR Evaluation. Resident #23 Record review of Resident #23's electronic face sheet dated 05/29/2025 revealed a [AGE] year-old female initially admitted to the facility on [DATE]. The face sheet included the following diagnoses: o (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Benign neoplasm of meninges, unspecified (non-cancerous, abnormal growth (tumor) that arises from the protective lining around the brain and spinal cord), Primary, with an onset date of 09/10/2024. o Hydrocephalus, Unspecified (buildup of fluid in cavities (ventricles) deep within the brain), Secondary, with an onset date of 09/10/2024. o Personal History of Traumatic Brain Injury, Secondary, with an onset date of 08/20/2024. o Unspecified Mood (affective) Disorder (symptoms that are characteristic of a depressive disorder and cause clinically significant distress or impairment), Secondary, with an onset date of 08/20/2024. The document did not indicate Resident #23 had a primary diagnosis of dementia. Record review of Resident #23's Quarterly MDS dated [DATE], revealed under Section C Cognitive Patterns, Resident #23's MDS revealed a BIMS of 7, indicating the resident was significantly, cognitively impaired. There was not an option on Resident #23's MDS, under section I Psychiatric/Mood Disorder, related to unspecified Mood Disorder. Record review of Resident #23's care plan with a last Care Plan review date of 04/14/2025, under Diagnoses, indicated Resident #23 had a diagnosis of Unspecified Mood (Affective) Disorder. Additionally, the care plan included a focus area that began on 11/13/2024 which stated, Resident is on neuro stimulant for mood disorder, with a goal that was revised on 11/13/2024 which stated, The resident will be free from discomfort or adverse reactions related to neuro stimulant therapy through the review date., with the Interventions/Tasks that included the following: Educate the resident/family/caregivers about the risks, benefits, and the side effects and/or toxic symptoms of neuro stimulant. Date Initiated: 11/13/2024; Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. Date Initiated: 11/13/2024. Record review of Resident #23's physician's Order Summary as of 05/29/2025 revealed under Diagnoses Unspecified Mood (Affective) Disorder. Resident #23 was prescribed Sertraline HCl (hydrochloride) Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth at bedtime related to Unspecified Mood (Affective) Disorder. Record review of Resident #23's Preadmission Screening and Resident Review (PASRR) Level One (PL1) form dated 09/20/2014 revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. There were no additional PL1 screenings provided by the facility for Resident #23. There were no additional documents provided to suggest Resident #23 had a completed PASRR Evaluation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/2025 at 10:20 AM, RN A stated she was the MDS and PASRR coordinator. RN A stated she was responsible for entering a Rresident's PASRR upon admission. RN A stated she was also responsible for requesting an update if there were any changes needed to a Rresident's PASRR. RN A stated she entered PASRR screenings upon admission, as they were received. RN A stated she did not compare a Resident's diagnoses to the resident's PASRR upon admission, as she assumed the PASRR the facility received was accurate. RN A stated she did not realize this was something she should have done previously. RN A stated she relied on the previously completed PASRR to determine if a Resident had a positive PASRR. RN A stated she would only have submitted a form to request a PASRR to be updated if a Resident had a new diagnosis of a mental illness. RN A stated she thought any diagnosis of dementia would have caused a Resident to have a negative PASRR, and she was not aware the diagnosis of dementia should be the Resident's primary diagnosis to exclude the Resident from a positive PASRR. RN A stated she thought a Resident's diagnosis of mental illness would depend on the severity to determine if the Resident qualified for a positive PASRR. RN A stated Resident #7 did not have a primary diagnosis of dementia, and Resident #7 had a diagnosis of a mental illness. RN A stated, based on that information, Resident #7 should have had a positive PASRR. RN A stated Resident #23 did not have a diagnosis of dementia, and Resident #23 had a diagnosis of mental illness. RN A stated, based on that information, Resident #23 should have had a positive PASRR. RN A stated she believed the reason Resident #7 and Resident #23 did not have a positive PASRR was because they were completed incorrectly prior to the residents being admitted to the facility, and she was not aware she should have requested they be updated. RN A stated she was trained on PASRR via online webinars. RN A stated she would review the PASRR criteria again and request an updated PASRR for Resident #7 and Resident #23, as soon as possible. RN A stated she did not feel Resident #7 or Resident #23 were negatively affected by having an inaccurate PASRR screening since they were being offered psychiatric services. RN A stated if a Resident's PASRR was not accurate, the Resident may not be offered services they could have benefitted from. During an interview on 05/30/2025 at 10:35 AM, the DON stated RN A was responsible for entering a Resident's PASRR, upon admission. The DON stated she was also responsible for reviewing the PASRR prior to admission to ensure the facility was able to meet the needs of the resident. The DON stated RN A should have checked each PASRR for accuracy, and RN A should have requested an updated PASRR if it was not accurate. The DON stated she was unsure of which specific mental illness would have met the criteria for a positive PASRR, and she would need to look it up to verify it. The DON stated, to her knowledge, major depressive disorder, psychotic disorder, and unspecified mood (affective) disorder should have qualified a Resident for a positive PASRR. The DON stated she received training online pertaining to PASRR. The DON stated it was important for a Resident to have an accurate PASRR to ensure the Resident was receiving services related to their mental illness if the Resident wanted services. During an interview on 05/30/2025 at 10:55 AM, the ADM stated RN A was responsible for entering a Resident's PASRR, upon admission. The ADM stated it was his expectation that RN A ensured a Resident's PASRR was accurate based on the Resident's diagnosis. The ADM stated he believed major depressive disorder, psychotic disorder, and unspecified mood (affective) disorder should have qualified a Resident for a positive PASRR. The ADM stated if the PASRR was completed incorrectly prior to admission, it was his expectation the PASRR would be updated as soon as possible after admission. The ADM stated all facility staff received training on PASRR via online webinars. The ADM stated he planned to begin reviewing a resident's PASRR to assist RN A, to ensure each PASRR was accurate. The ADM sated if a resident's PASRR was not accurate, it could affect the care the Resident received, and the Resident may miss services they qualified for. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, PASRR Level 1 Screen Policy and Procedure, revised 03/06/2019 revealed the following: Policy: It is the policy of (redacted organization) facilities to obtain a PLI screening form from the RE (referring entity) prior to admission to the NF (nursing facility). Procedure: The Facility will review the PLI Screening Form for completion and correctness prior to admission and submit the PLI form per regulations. The Type of admission is reviewed for correctness. Ensure the Name, SS number, Medicare/Medicaid numbers and DOB is correct. The Date of the PLI is correct (i.e. correct day, month and year) and review each item on the PLI to ensure accuracy and prevent a regulatory problem.