

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Pampa Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W Kentucky Pampa, TX 79065	
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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**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 #1) of 5 residents reviewed for advanced directives. Resident #1's DNR form lacked dated witness acknowledgments and therefore was not fully executed. This failure could place residents at risk of receiving medical treatment inconsistent with their or their legal representative's expressed wishes. Findings included: Record review of Resident #1's face sheet dated [DATE] revealed he was an [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses including but not limited to Cerebral Infarction (stroke), Frontal Lobe and executive function deficit following cerebral infarction (damage to the frontal lobe due to stroke), and Parkinson's disease without dyskinesia (neurological disorder). Resident #1 was identified as a DNR in the Advance Directive section. Record review of Resident #1's quarterly MDS Assessment was completed on [DATE]. In section C0500 the BIMS Summary Score reflected a 02 out of 15 indicating severe cognition impairment. Record review of Resident #1's care plan revised on [DATE] included the following: Focus: I choose to have a DNR Code status. Please do not provide CPR. Record review of Resident #1's active physician orders as of [DATE] revealed the following order: DNR (Do not resuscitate) dated [DATE]. Record review of the clinical record for Resident #1 revealed a DNR document signed by Resident #1's representative and physician dated [DATE]. Under the Two Witnesses section: two witnesses' signatures; however, neither witness signature was dated. During an interview on [DATE] at 3:45 PM, the MDS RN stated she was responsible for verifying the DNR documents were accurate. Upon reviewing the DNR document, the MDS RN stated the witness signatures were not dated. The MDS RN said she would still honor the DNR because the Resident's Representative and physician signed and dated it. When asked how verification occurred without dated witness signatures, the MDS RN stated she did not know. During an interview on [DATE] at 4:25 PM, LVN A stated a DNR would not be valid if the witnesses' signatures were not dated. LVN A said a potential negative outcome for a resident with an inaccurate DNR would be the resident would be treated as a full code, which would be against the resident's wishes. LVN A said the MDS RN, and DON were responsible for ensuring the DNR documents were correct. During an interview on [DATE] at 4:30 PM, the DON reviewed Resident #1's DNR and stated it was not correct due to the missing witnesses' dates. The DON stated that she and the MDS RN were responsible for ensuring DNR documents were accurate and stated that the potential outcome could be CPR being initiated for a resident who had elected DNR status. Record review of a blank OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES 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 professional. Record review of facility policy Do Not Resuscitate Order dated [DATE] revealed. Our facility will not use cardiopulmonary resuscitation and related emergency measure to main life functions on a resident when there is a Do Not Resuscitate Order.</p>		

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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