

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 06/25/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813</p> <p>Based on interview and record review, the facility failed to notify the resident or a representative of the Office of the State Long-Term Care Ombudsman of the transfer or discharge for 1 (Resident #30) of 3 residents reviewed for transfers/discharges.</p> <p>The facility failed to notify Resident #30 of her transfer to the hospital and pending discharge.</p> <p>The facility failed to notify a representative of the Office of the State Long-Term Care Ombudsman of Resident #30's discharge.</p> <p>This failure could affect residents at the facility by placing them at risk of being transferred/discharged and not having access to available advocacy services, discharge/transfer options, and appeal processes.</p> <p>Findings include:</p> <p>Record review of Resident #30's face sheet dated 06-24-2024 revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), pneumonia (lung inflammation caused by a bacterial or viral infection), expressive language disorder (a condition in which a person has lower than normal ability in vocabulary, saying complex sentences, and remembering words), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), hypertension (a condition in which the force of the blood against the artery walls is too high), chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), atherosclerotic heart disease (a buildup of fat, cholesterol, and other substances in the artery walls), psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions), and dementia. (a group of thinking and social symptoms that interferes with daily functioning). Section-Miscellaneous Information-Date of Discharge-05-13-2024. discharged to: Acute Care Hospital. Section-Contacts-Resident #30 is listed as the Responsible Party. No other contacts are listed.</p> <p>(continued on next page)</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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #30's last MDS assessment completed 5-13-2024 reflected a discharge assessment-return not anticipated listing Resident #30 with a BIMS that was not evaluated because Resident #30 had memory problems and that Resident #30 had a functionality that ranged from substantial/maximal assistance with activities of daily living such as dressing and footwear to independent with eating. Section A marked the discharge as unplanned.</p> <p>Record review of Resident #30's discharge MDS completed 5-13-2024 also revealed the following:</p> <p>Section A:</p> <p>At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? -there was no response.</p> <p>Section O:</p> <p>Is active discharge planning already occurring for the resident to return to the community? -the answer was no.</p> <p>Record review of Resident #30's care plan with admitted [DATE] revealed the following care plan:</p> <p>Focus-I wish to remain in the facility for long term care. Date Initiated: 05-10-2024.</p> <p>Record review of Resident #30's chart to include Resident #30's progress notes dated 04-24-2024 to 05-25-2024 revealed the following:</p> <p>The first documented progress note was 04-24-2024 and the last documented progress note was 05-13-2024.</p> <p>-There was no documentation in the progress notes or any other area of Resident #30's chart for Resident #30's transfer/discharge, the reason for Resident #30's transfer/discharge, no noted discharge summary, no noted notification of the resident since Resident #30 was her own responsible party. There was no noted notification of the Ombudsman of Resident #30's transfer/discharge or reason for the transfer/discharge.</p> <p>During an interview on 06-24-2024 at 03:07 PM the DON verified that Resident #30 was discharged to theER on [DATE] after having behavioral issues with staff, Police, and the EMS and the plan was that Resident #30 would not return due to being a risk to the other residents and staff. The DON reported that at the time of this interview the facility did not know where Resident #30 was or what had happened to Resident #30. The DON reported that the plan was for Resident #30 to go to a behavioral health unit but that she (the DON) did not know if that had happened. The DON reported that no written notice of transfer or discharge had been given to Resident #30 and to the DON's knowledge no notice had been sent to the ombudsman. The DON also reported that no notice that Resident #30 would not be allowed to be readmitted to the facility was given either but that that was the administrator's responsibility and that this surveyor would need to ask the administrator for verification.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/24/24 at 03:11 PM the Administrator reported that no written transfer or discharge notice and no written notice that Resident #30 would not be readmitted to the facility had been given to Resident #30 due to Resident #30 was a risk to the other residents and staff. The Administrator stated, I honestly can't recall if we notified the Ombudsman of any of this due to Resident #30 was such a threat and we knew Resident #30 would not be readmitted . The administrator checked her computer to include Resident #30's chart and the Administrator's emails and could not find any notice of transfer or discharge that was provided to Resident #30 or the Ombudsman.</p> <p>During an interview on 06-24-2024 at 03:57 PM the Ombudsman for this facility checked her records and verified that she has never received a notice of transfer or discharge for Resident #30. The Ombudsman reported that she was supposed to receive a monthly list of transfers or discharges but this facility is bad about not sending them.</p> <p>During an interview on 06-25-2024 at 07:45 AM the Administrator reported that if a resident or the ombudsman was not provided the information of a residents transfer or discharge then it could be a violation of the resident's rights and the residents would not get the right to appeal the transfer or discharge.</p> <p>During an interview on 06-25-2024 at 08:14 AM the DON reported that if a resident was not given a transfer or discharge notice and the information included with the transfer or discharge notice then that resident would not have the information for the appeal process.</p> <p>Record review of the facility provided policy titled, Transfer or Discharge, Facility-Initiated October 2022, revealed the following:</p> <p>Policy Statement: Once admitted to the facility, residents have the right to remain in the facility. Facility initiated discharge, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.</p> <p>-Notice of Transfer or Discharge (Emergent or Therapeutic Leave)</p> <p>4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) Ombudsman when practicable (e.g. in a monthly list of residents .)</p> <p>-Notice of Discharge after Transfer</p> <p>2. If the facility does not permit a resident to return to the facility based on inability to meet the residents needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of the appeal rights.</p> <p>3. The facility will send a copy of the discharge notice to the representative of the Office of the State LTC Ombudsman.</p> <p>-Documentation of Facility-Initiated Transfer or Discharge</p> <p>1, When a resident is transferred or discharge from the facility, the following information is documented in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. The basis for the transfer or discharge</p> <p>b. That appropriate notice was provided to the resident .</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813</p> <p>Based on interview, and record review the facility failed to review the risks and benefits of bed rails with the resident or resident's representative and obtain informed consent prior to installation of bed rails for 2 (Resident #20 and #24) of 17 residents reviewed for bedrails.</p> <p>The facility failed to inform Resident #20 and #24 or their representatives for the use of bed rails and obtain consent for the use of bed rails.</p> <p>This deficient practice could place all residents with bed rails at risk for injuries such as abrasion, fractures, and entrapment.</p> <p>Finding include:</p> <p>Resident #20</p> <p>Record review of Resident #20's clinical record revealed an [AGE] year-old male admitted to the facility originally on 01-4-2023 and readmitted on [DATE] with diagnoses to include cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), Parkinson's (a disorder of the central nervous system that affects movements to include tremors), hypertension (a condition in which the force of the blood against the artery walls is too high), repeated falls, macular degeneration (a degenerative condition affecting the central part of the retina), lack of coordination, muscle weakness, and dementia (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>Record review of Resident #20's clinical record revealed his last MDS was a quarterly completed 03-12-2024 which indicated his BIMS was 15 indicating he was cognitively intact, and he had a functionality of requiring substantial/maximal assistance with most activities of daily living. Resident #20 is listed as requiring supervision or touching assistance when transferring from the bed to the chair.</p> <p>Record review of Resident #20's Order Summary Report with active orders as of 06-24-2024 revealed the following order:</p> <p>Device: Side Rail: Three Fourth Side Rail - Active 01-04-2023</p> <p>Record review of Resident #20's care plans with date of admit 07-08-2023 revealed the following care plan:</p> <p>Focus - I use 1/4 side rails on both sides of my bed for increased bed mobility and positioning. - Date Initiated: 04-24-2023.</p> <p>Record review of Resident #20's clinical record revealed a Bed Rail Consent undated that was not completed and had no signature for Resident #20 or his representative.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 06-23-2024 at 09:26 AM Resident #20 was in his wheelchair in his room. Resident #20 had bilateral 1/4 bedrails that were up and locked in place that he reported he uses to move around in his bed, that he knew how to use the bedrails, but the facility had not addressed any issues with his bed rails to include training him on their use. Resident #20 was noted to have a right-hand contracture (a condition of shortening and hardening of the muscles and tendons, or other tissue, often leading to deformity and rigidity of the joints).</p> <p>Resident #24</p> <p>Record review of Resident #24's clinical record revealed an [AGE] year-old male admitted to the facility on originally on 11-30-2023 and readmitted on [DATE] with diagnoses to include acquired absence of right leg below the knee (surgical amputation below the knee of the right leg), hypertension (a condition in which the force of the blood against the artery walls is too high), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose)), depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), congestive heart failure (a chronic condition in which the heart dose not pump blood as well as it should), and malaise (a general feeling of discomfort, illness, lack of well-being).</p> <p>Record review of Resident #24's clinical record revealed his last MDS was a quarterly completed 03-15-2024 which indicated his BIMS was 13 indicating he was cognitively intact, and he had a functionality of requiring partial/moderate assistance with most activities of daily living. Resident #24 is listed as requiring supervision or touching assistance when transferring from the bed to the chair.</p> <p>Record review of Resident #24's Order Summary Report with active orders as of 06-24-2024 revealed no orders for his bedrails.</p> <p>Record review of Resident #24's care plans with date of admit 01-02-2024 revealed the following care plan:</p> <p>Focus - I am at high risk for falls r/t Gait/balance problems. - Date Initiated: 12-17-2023.</p> <p>Interventions - The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide rails (bed rails) as ordered, handrails on walls, personal items within reach) - Date Initiated: 12-17-2023.</p> <p>Record review of Resident #24's clinical record revealed there was no bedrail consent completed for Resident #24.</p> <p>During an observation and interview on 06-23-2024 at 09:22 AM Resident #24 was in his room laying in his bed under his covers. Resident #24 had bilateral 1/4 bedrails up and locked in place. Resident #24 reported that he used his bed rails a little bit and that he did not know how to use them properly or how to get them up and down if needed, that the facility had never discussed his bed rails with him to include training him on their use.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06-25-2024 at 07:41 AM the Administrator reported that Resident #20 had a bedrail consent in his chart that was never signed, and Resident #20 had a family representative that was his responsible party, and that Resident #24 did not have any bedrail consent in his chart. The Administrator reported that she was going to get the family to come in and sign Resident #20's consent and that she would get Resident #24's consent signed immediately.</p> <p>During an interview on 06-25-2024 at 07:49 AM the Administrator reported that if a resident was not offered the consent information for bedrails and given the opportunity to accept or refuse the consent then it violates a residents' right to choose self-preservation which could pose a risk to the resident of becoming trapped in the rail or being injured.</p> <p>During an interview on 06-25-2024 at 08:15 AM the DON reported that if a resident was not given the opportunity to address a bedrail consent, then the resident might hurt themselves on the bedrail and their safety would not be maintained.</p> <p>Record review of facility provided policy titled Bed Safety and Bed Rails, revision August 2022, revealed the following:</p> <p>Use of Bed Rails</p> <p>8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>39813</p> <p>Based on observation, interview, and record review; the facility failed to ensure medications were stored in accordance with currently accepted professional principles for 1 (North Hall Medication Cart) of 4 medication storage areas reviewed for medication storage.</p> <p>LVN F left the North Hall medication cart unlocked and unsupervised in the hallway.</p> <p>The facility's failure to ensure medications were stored in accordance with currently accepted professional principles could result in a residents, visitors, or staff accessing the resident medications resulting in misappropriation of resident property, exacerbation of the resident's condition, overdose, and exacerbation of the resident's disease processes.</p> <p>Findings included:</p> <p>During an observation on 06-23-2024 at 03:09 PM of the North Hall medication cart that was placed at the front of the north hall in the hallway in front of the nurse's station, the cart was noted to be unlocked. This surveyor noted on several occasions during this shift that resident have been present in this hallway to include resident who are wondering and confused. No staff or residents were present at the time of this observation.</p> <p>During an observation and interview on 06-23-2024 at 03:11 PM ADON E was asked to exit her office and check the North Hall medication cart. ADON E verified that the North Hall medication cart was unlocked, and that multiple resident medication were present in the cart. ADON E reported that leaving a medication cart unattended and unlocked can result in residents or family members accessing the medications, that if that happened the person taking the medications could have a reaction, it could be dangerous, and they could take too much of something and overdose.</p> <p>During an interview on 06-23-2024 at 03:15 PM LVN F (the nurse responsible for the North Hall medication cart this shift) reported that she never leaves her cart unlocked and that she did not know what happened this time. LVN F reported that leaving a medication cart unlocked could result in resident medications getting stolen, residents who wonder could access the meds, and that a resident could die if they took the wrong medication or took too much medication. LVN F reported that it was the facility's normal protocol to ensure all medication carts are locked when staff are not present and that she had been trained on this by a previous DON.</p> <p>Record review of the facility provided polity titled, Storage of Medications revised November 2020, revealed the following:</p> <p>Policy:</p> <p>The facility stores all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>Policy Interpretation and Implementation:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1.-Drugs and biologicals used in the facility are stored in locked compartments . Only persons authorized to prepare and administer medications have access to locked medication.</p> <p>6.-Compartments (including . carts .) containing drugs and biologicals are locked when not in used. Unlocked medication carts are not left unattended.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882</p> <p>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.</p> <ol style="list-style-type: none"> The facility failed to ensure freezer items were properly stored, labeled, and dated. The facility failed to ensure personal items were not in the prep area. The facility failed to ensure pantry foods were properly stored, labeled, and dated. The facility failed to ensure proper hand hygiene and glove use was practiced. The facility failed to ensure cleanliness in the kitchen. <p>These failures could place residents who ate food served by the kitchen at risk of food-borne illness.</p> <p>Findings include:</p> <p>Observation of the freezer on [DATE] at 9:20 AM revealed the following:</p> <ol style="list-style-type: none"> (1) Ziplock bag of coconut with a use by date of [DATE]. (1) box of frozen vegetables , not sealed and open to air. (1) box of frozen cookie dough, not sealed and open to air. (1) box of frozen biscuit dough, not sealed and open to air. (1) box of frozen omelets, not sealed and open to air. (1) box of frozen sausage patties, not sealed and open to air. (1) box of frozen bacon, not sealed and open to air. Food crumbs were observed in the floor of the freezer. <p>Observation of the walk-in pantry on [DATE] at 9:26 AM revealed the following:</p> <ol style="list-style-type: none"> (1) Ziplock bag of spaghetti noodles, no label or date. Food crumbs were observed on the floor of the pantry and under the food storage racks. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an observation and an interview of the kitchen prep area on [DATE] at 9:30 am revealed the following:</p> <ol style="list-style-type: none"> (1) ladies' purse on the lower shelf of the kitchen prep table with kitchen pots and paper products. [NAME] A stated the purse was hers and she did not know she was not supposed to have personal items in the kitchen prep area. She stated she did not know what the consequences would be if her purse was in the kitchen prep area. <p>In an observation and interview on [DATE] at 12:05 pm [NAME] B was observed with gloved hands to touch food trays, the rolling cart next to the prep table, the kitchen prep table, condiment packages and picked up a dessert cup and placed it on a resident meal tray. [NAME] B picked up a dinner roll with one hand and pulled other rolls away from the first roll with her other hand. [NAME] B placed the roll on the plate of food. [NAME] B did not wash her hands or change her gloves. [NAME] B stated she did not use tongs because she had gloves on.</p> <p>In an observation on ,d+[DATE]/ 24 of the freezer on [DATE] at 10:00 AM revealed the following:</p> <ol style="list-style-type: none"> (1) box of frozen vegetables, not sealed and open to air. (1) box of frozen cookie dough, not sealed and open to air. (1) box of frozen biscuit dough, not sealed and open to air. (1) box of frozen sausage patties, not sealed and open to air. Food crumbs were observed in the floor of the freezer. <p>Observation of the walk-in pantry on [DATE] at 10:06 AM revealed the following:</p> <ol style="list-style-type: none"> (1) Ziplock bag of spaghetti noodles, no label or date. Plastic cup lids in floor of pantry and on top of the canned food in the canned food rack <p>In an interview on [DATE] at 2:20 PM, the DM stated of the opened food products she expects all staff to close food items up after use and she expected all food to be labeled and dated. She stated if foods were not properly wrapped up or labeled and dated this could cause food contamination and sickness to residents. She stated anything could fall into the opened food items. She stated expired food items should be thrown out if expired and not used as this could make residents sick. The DM stated she expects all staff to use tongs to serve bread and rolls. The DM stated s personal items are not supposed to be in the kitchen prep area. She stated she had a hook on the back of the kitchen that staff should use for personal items. She stated having personal items in the kitchen could cause cross contamination. The DM stated she was responsible for training staff, and she would retrain them.</p> <p>(continued on next page)</p>		

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 06/25/2024
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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record Review of the facility policy and procedure, dated 2009, titled Safe Food Handling documented employees wash hands prior to handling food. Follow all local state and federal regulations when handling food. Refrigerated foods are properly covered, labeled and dated. Food is served with clean sanitized utensils. There is no bare hand contact. All foods removed from the original packaging are stored in a closed container and labeled with the common name of the product and the date it was opened.</p> <p>Record Review of the facility policy and procedure, dated 2009, titled Indications for Glove Use documented employees must wash hands before putting on gloves, when changing into fresh gloves and immediately after removing gloves. Change gloves when an unsanitary item is touched. Examples include opening a drawer, touching a dirty plate, turning on a faucet .Change gloves when beginning a different task.</p> <p>Record Review of the facility policy and procedure, dated 2009, titled Safe Food Preparation documented Avoid touching ready to eat foods with bare hands. Use tongs or other utensils instead.</p> <p>Record Review of the facility policy and procedure, dated 2009, titled Food Safety in Receiving and Storage documented Refrigerated food items are properly covered, labeled and clearly marked to indicate a use by date 2 months from the date opened.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47854</p> <p>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 1 (Resident #23) of 17 Residents.</p> <p>-CNA A and CNA B failed to use proper hand hygiene before, during, and after incontinent care of Resident #23.</p> <p>These failures had the potential to affect residents in the facility 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.</p> <p>Findings included:</p> <p>Observation on 06/24/24 at 12:56pm of incontinent care for Resident #23 was performed by CNA C and CNA D. Hand hygiene was not performed before the start of incontinent care for Resident #23 by either CNA. Resident #23 had a BM and CNA D turned resident away from her towards the wall to clean Resident #23's buttocks and rectum. CNA D then proceeded to take a clean brief and place it under the resident. No hand hygiene or glove change took place during this observation. CNA D then with the same dirty gloves that she performed incontinent care with, touched residents' blankets, pillow, and clothing of resident. No hand hygiene was performed by CNA D after removal of gloves in room. CNA D was observed taking waste to the dirty linen closet and did not perform hand hygiene after taking trash to the dirty linen closet. CNA C removed gloves and provided Resident #23 with a drink of coke. No HH was performed until after the drink was provided to resident.</p> <p>Interview on 06/24/24 at 01:27pm CNA D stated that there was no negative outcome by not performing HH or a glove change. CNA D was asked if there was any chance for infection if she did not perform HH or glove change, CNA D stated yes.</p> <p>Interview on 06/24/24 at 01:30pm CNA C stated that a negative outcome for not performing hand hygiene before administering the drink to Resident #23 would lead to cross contamination.</p> <p>Interview on 06/25/24 at 8:18am DON stated that a negative outcome for not performing hand hygiene and glove changes during incontinent care could lead to cross contamination.</p> <p>Record review of facility provided policy, titled Handwashing/Hand Hygiene, revised August 2019, revealed the following:</p> <p>Policy Statement</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>Policy Interpretation and Implementation</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.</p> <p>2. all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>.7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-anti-antimicrobial) and water for the following situations: .</p> <p>.b Before and after direct contact with residents; .</p> <p>.h. Before moving from a contaminated body site to a clean body site during resident care; .</p> <p>.m After removing gloves; .</p> <p>.o. before and after eating or handling food;;;;</p> <p>p. Before and after assisting a resident with meals; .</p> <p>.8. Hand hygiene is the final step after removing and disposing of personal protective equipment.</p> <p>.Applying and removing gloves:</p> <p>1. Perform hand hygiene before applying non-sterile gloves .</p> <p>.5. Perform hand hygiene.</p> <p>Record review of facility provided policy, titled Perineal Care, revised February 2018, revealed the following:</p> <p>Steps in procedure .</p> <p>.2. Wash and dry your hands thoroughly.</p> <p>.7. Put on gloves.</p> <p>.10. Remove gloves and discard into a designated container.</p> <p>11. wash and dry your hands thoroughly.</p>