STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455513	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lampasas Nursing and Rehabilitation Center	611 N Broad St Lampasas, TX 76550

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 8 Resident reviewed for quality of care. The facility failed to ensure MA A notified LVN B on [DATE] when Resident #1's BP reading was 86/54 on [DATE], which is far from baseline. Resident #1 was sent to the ER on [DATE] and was diagnosed with Sepsis (a serious condition that occurs when the body has an extreme reaction to an infection leading to widespread inflammation and potential organ dysfunction.) and Hypotension (or low plod pressure is a condition where blood pressure is lower than 90/60 mm Hg. It can occur as a standalone condition or as a symptom of other health issues). Resident #1 died 2 days later while in the hospital. This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE] at 5:08 pm and an IJ template was given. While the IJ was removed on [DATE] at 4:37 pm the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for not being provided the care/treatment required to meet their needs. Findings included: Review of Resident # 1's face sheet dated [DATE] reflected an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses that included: Acute Respiratory failure (is a serious condition that occurs when the lungs cannot adequately exchange gases, leading to low oxygen level and potentially high carbon dioxide levels.), Hypertension (or high blood pressure is defined as a blood pressure reading of 130/80 mm Hg), Pneumonia (is an inflammatory condition of the lungs primarily caused by infection from bacteria, viruses, or fungi), Asthma (is a common long-term inflammatory disease of the airways in the lungs. It occurs when allergen or irritants are inhaled, causing the airway to constrict and produce mucus which restricts airflow), Respiratory failure (a condition where you don't have enough oxygen or too much carbon dioxide in your body), COPD (is a lung condition caused by damage to the airways and alveoli, usually from smoking or other irritants.). Review of Resident #1's significant change MDS dated [DATE] indicated he had a BIMS score of 8 indicating moderate cognitive impairment. Section I: Active Diagnosis reflected Resident #1 had Hypertension, Pneumonia, Asthma, Respiratory failure. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan initiated [DATE] reflected Resident #1 had Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease, due to Congestive Heart Failure, Respiratory failure; Alteration in Respiratory Status Due to Pneumonia: Impaired Cardiovascular status related to: Deep Vein Thrombosis, Hypertension, HLD (Hyperlipidemia- High-density lipoprotein), AFib (is an irregular and often very rapid heart rhythm that can lead to blood clot, stroke and heart failure), diuretic therapy. Impaired Cardiovascular status related to deep vein thrombosis, Hypertension HLD, AFib, diuretic therapy with interventions of medications as ordered by physician and observe use and effectiveness, observe and report signs of chest pain, edema, SOB, abnormal pedal pulse, restlessness, and fatigue. Review of Resident #1's physician order reflected: Losartan Potassium Oral Tablet 100 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN -Order Date- [DATE] Review of Resident #1's vitals in her EMR reflected a BP of 86/54 on [DATE] at 10:50 am and 75/41 on [DATE] at 8:12 am. Review of Resident #1's NP progress note, dated [DATE], reflected that orders were given to check vitals BID and if Resident #1 became symptomatic such as lethargy, confusion, nausea/vomiting and bradycardia or if there was any change to Resident #1's BP, to send to the ER. Review of Resident #1's progress notes dated [DATE] at 08:00 am written by RN C reflected: Resident noted be unresponsive this morning. Vital signs 75/41, 94, 22, 97.7 93% on 4l N/C. Message left for NP that resident was being sent out. Message left for [family] at 0736. [Another family] here and notified that resident was being transferred to [local hospital]. DON notified. Review of Resident #1's progress notes dated [DATE] at 12:31 pm written by RN C reflected: Call made to [local hospital] to check on resident. Per ED nurse resident is being admitted to ICU room [xxx] with diagnosis of hypotension and sepsis. Message left with her [family] to update. During an interview on [DATE] at 2:09 pm MA A stated the top number of blood pressure should be over 100 and the bottom number should be over 60. MA A stated she relayed the message to LVN B before she left that Resident #1 was not doing good. She stated she should have checked her BP if she knew she was not doing good. MA A stated she held Resident #1's blood pressure medication on [DATE] due to Resident #1's blood pressure being low, but she did not notify LVN B. MA A stated she worked the 12 hours shift, from 8:00 am to 8:00 pm on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:44 pm the Interim DON stated Blood pressure systolic range is different for each resident because they are on blood pressure medication that can affect blood pressure. The Interim DON stated, if the blood pressure was accurate, she would think the staff would call the NP and get order to send to Resident #1to the ER. The Interim DON stated, if a medication aide took the blood pressure and it was low, the medication aide should be notifying the nurse. The Interim DON stated, I would expect them to tell the nurse what the blood pressure reading were, the facts, the vitals and anything that they saw clinically. You need to keep an eye on the Resident because she doesn't look good is not a good way to notify the nurse. These are my vitals; this is what I saw and observed is what they should be telling the nurses. The Interim DON stated low blood pressure can be a sign of sepsis. The Interim DON stated many things are the signs of sepsis, the MA should have reported that B/P reading to the nurse. During an interview on [DATE] at 3:00 pm the NP stated a blood pressure of 86/54 is low, and she would have liked for the staff to have notified her so that she could have treated Resident #1. The NP stated she would have sent Resident #1 out to the hospital the same day, especially since Resident #1 had history of being septic from UTI/ PNA. The NP stated she was never notified of Resident #1's hypotension. The NP stated the sepsis caused the hypotension because she was not being treated for any infection at the time of her transfer to the ER. I would have sent her out. During an interview on [DATE] at about 3:15 pm, according to the ADON, Interim DON, Interim Administrator, Resident #1 died in the hospital about two days after she was transferred to the hospital due to Kidney failure. During an interview on [DATE] at 3:35 pm LVN B stated she was not notified by MA A of Resident #1's low BP on [DATE]. LVN B stated if she had been notified, she would have re-checked Resident #1's blood pressure manually and notified the NP . Requested Resident #1's hospital records from the facility and hospital, did not get it upon exit. Review of the facility's policy titled Notification of Change in Patient/Resident Health Status dated [DATE] reflected: Purpose -- To ensure all interested parties were informed of the resident's change in health status so that a treatment plan could be developed which is in the best interest of the resident. Process--The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the patient representative when there is: (D)A decision to transfer or discharge the resident from the center. Notification will be immediate. Definition: Immediate means as soon as possible no longer than 24 hours. The Administrator and ADON were notified on [DATE] at 5:08 pm that an IJ had been identified and an IJ template was provided. A plan of removal was requested. The following POR was accepted on [DATE] at 01:30 pm (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Jeopardy Allegation of Compliance [DATE] To the best of my knowledge and belief, as an agent of (facility), the following allegation of compliance constitutes a written plan demonstrating actions the center took upon awareness of the deficient practice thus removing the Immediate Jeopardy cited on [DATE]. Preparation and execution of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. The allegation of compliance is prepared and/or executed solely because it is required by the provisions of Federal and State Law. F684 - The facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the patient representative when there is: (D)A decision to transfer or discharge the resident from the center. Notification will be immediate. Immediate Actions for All Residents Potentially Affected: DNS notified the Medical Director of the incident. Completed on [DATE]. Education provided by DNS on duty nursing staff regarding change of condition guidelines and expectation. Completed 6.12.25. Comprehension was validated via a post test. Education provided to on duty nursing staff by the DNS regarding timely notification of change to MD/NP and Responsible Party Nurses completed blood pressure assessments on all residents to identify any changes in condition and notification was made to the physician of any noted changes. No concerns were identified. Completed 6.12. 25. This was completed by inputting resident baselines in our EMR (PCC) that will alert staff. Inservice on this was completed 06-13-25. The ADM removed the CMA and Nurse from patient care until they were educated on a 1:1 basis regarding the change in condition and physician notification guideline. Comprehension was validated via posttest. Completed 6.13.25. The Senior DCO educated the DNS on 6.12.25 regarding the change of condition and physician notification guideline. The DON signed statement of training provided via email from Senior Director of Clinical Operations. Systematic Changes Completed: The DON implemented disciplinary action with staff was aware of significant change but did not report it to the physician. This was completed by 1:1 in-services and progressive discipline. Post test was completed to validate comprehension. Completed 6.13.25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No nursing staff will be allowed to work before being educated on the change of condition and physician notification guideline. This was initiated on 6.12.25. New hires (licensed nurses and CMAs) will be educated on change of condition and physician notification guidelines, as well as facility policy and procedure, accordingly in orientation by human resources/designee. Initiated on 6.12.25., QAPI: On 6.12.25 the DNS implemented a Quality Assurance Performance Improvement (QAPI) plan to include completing a chart (audit ad hoc QAPI signed and acknowledged by DON, Admin and Medical Director) of assessments as follows: Three residents weekly for four weeks Two residents weekly for two weeks Two residents a month for two months The results of the audit will be discussed in daily startup and then in monthly QAPI with follow up as needed. A focused QAPI meeting addressing this event and findings was initiated and completed on [DATE] at 7:00 P. M with the attendance of the Administrator, DNS, and Medical Director. In summary, upon awareness, the center acted swiftly with the corrective actions, team member re-education, and ensured auditing measures were in place to monitor the plan. The center corrected the process and address the identified deficient practice immediately and completed actions. The Surveyor monitored the POR on [DATE] from 1:46 pm to 4:36 pm as followed: During interviews on [DATE] from 1:46 pm to 2:02 pm, CNA F, NA G and NA H stated they were in-serviced by the Interim Administrator and DON on [DATE] on abuse and neglect and reporting change of Resident's condition to the charge nurses. They stated they were trained on checking on residents frequently and if they notice something different in a resident to report exactly what the changes were. They stated they had to complete a questionnaire after the training. During an interview on [DATE] at about 2:22 pm LVN B stated she was in-serviced by the Interim Administrator on [DATE] regarding abuse and neglect and change of condition. LVN B stated she was told to follow facility's policy, notify the NP/MD immediately of any change of condition. LVN B stated she had to complete a questionnaire after the training. LVN B stated the interim Administrator also asked her for a statement regarding Resident #1's incident. LVN B stated she was trained on alerts in PCC for vitals that were out of range. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at about 2:36 pm, LVN E stated she was in-serviced on [DATE] by the DON. LVN E stated she was in-serviced on Abuse and Neglect and Notification to the provider for change in condition of a resident. LVN E stated, if a medication was held or refusal of medication or swelling, notify the NP/MD as quick as you can. LVN E stated intervention should be follow by detail documentation. LVN E stated, if another staff report a Resident's change of condition, the nurse is supposed to assess the resident, take vital signs, do a change of condition form, Notify the NP/MD, give them a description of what you saw, what you assessed and let the NP/MD determine treatment plan. LVN E stated she also had to complete the questionnaires after the training/in-service. During an interview on [DATE] at 2:47 pm RN D stated she was in-serviced by the DON on 06/12/ and [DATE]. RN D stated, Yesterday was about abuse and neglect and change of condition. What to look for, who to notify, what to notify depending on your position. The CNAs and MA notify the nurses, the nurses notify the NP/MD, DON the family. The DON contacted the 2 doctor and got parameter for vital, and it was place in PCC. The DON and ADON put the parameters in PCC. If my CNA or medication aide says a resident doesn't look good, I am going to assess and report findings to the MD/NP, based on the orders send the resident out, notify the DON and the family. During an interview on [DATE] at 2:54 pm the ADON stated she had worked in the facility for about 4 days. The ADON stated she was in-serviced by the DON on 06/12 and [DATE]. The ADON stated in-services were on abuse and neglect and change of condition notification to the NP/MD. The DON stated on [DATE] they completed vitals for all Residents in the facility to get a baseline. The ADON stated on [DATE], the DON contacted the 2 providers and got parameter for vitals for each resident and added clinical alert in PCC for vital signs. The ADON stated it is the responsibility of the DON and the ADON to check every morning for clinical alert on PCC dashboard. The ADON demonstrated the process of checking clinical alerts. During an interview on [DATE] at 3:20 pm the Interim DON stated she was in-serviced by the SR DCO on Change of Condition/Physician Notification. The DON stated after she was trained/in-serviced, she in-serviced nursing staff on abuse and neglect and change of condition, notification to the NP/MD. The Interim DON stated the NAs, CNAs and MAs are expected to report change of condition to the nurses; the nurses are expected to immediately assess the residents and report findings to the NP/MD; the nurses are expected to follow the orders from the NP/MD and notify the resident's family. The Interim DON stated she contacted the NPs for the 2 MDs and got what they wanted for their parameters for vitals in PCC to set an alert for anything outside of that range. The Interim DON stated the nurses were in-serviced on that, they had access to the alert and should check it every shift. The Interim DON stated the DON or designee will check every day/morning. The Interim DON stated she and the ADON completed vitals on all resident s in the facility on [DATE] for a baseline. During an interview on [DATE] at 4:14 pm the Interim Administrator stated, We did 100% assessment of vitals for all the residents. The MD was notified of abnormalities. We also ensured all the residents had a baseline vitals in PCC. We did an Ad Hoc QAPI yesterday [DATE]. We started our in-service on change of condition and notification. No staff can work unless they were in-serviced, everyone that worked and is here have been in-serviced. We did abuse and neglect in-service for all staff including non-medical staff. We did progress discipline on [LVN B] and MA A; it was done 1:1, took statements from the 2 staff. Today we did an in-service on PCC alert for nurses and MAs, those that were here and the rest have to be in-serviced before working. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attempts made to contact MA A on [DATE] at about 4:25 pm but to no avail. Another attempt was made on [DATE] at 08:51 am. Later, during an interview on [DATE] at about 09:02 am, MA A stated she was called to the facility on [DATE] by the Interim Administrator for an in-service. MA A stated she was in-serviced on abuse and neglect and reporting change of condition to the nurses. MA A stated the Interim Administrator told her whenever there was a low blood pressure or something that was not normal to report to the nurses. MA A stated she completed the questionnaire after the training and the Interim Administrator asked her to write a statement. Review of facility's POR documents reflected the following: Education on Change of Condition/Physician Notification dated [DATE] provided by the SR DCO signed by the DON. Review of POR reflected an AD HOC QAPI was held on [DATE] with 3 signatures, The MD, Interim DON and the Interim DON. In-service initiated [DATE] reflected staff were in-serviced by the Interim DON and ADON on the following topics: Notification of change in Patient/Resident Health Status; Abuse, Neglect, Misappropriation, Exploitation. Was signed by 24 staff members. Audit records reflected Resident in the facility blood pressure checked was initiated on [DATE]. Progressive Discipline form dated [DATE] indicated Administrative Leave-Team member has been placed on administrative leave pending investigation and education resulting from a state survey on [DATE] signed by LVN B. In-service dated [DATE] reflected LVN B was in-serviced by the Interim Administrator on the following topics: Notification of change in Patient/Resident Health Status; Abuse, Neglect, Misappropriation, Exploitation. Was signed by LVN B. Progressive Discipline form dated [DATE] indicated Administrative Leave-Team member has been placed on administrative leave pending investigation and education resulting from a state survey on [DATE] signed by MA A. In-service dated [DATE] reflected MA A was in-serviced by the Interim Administrator on the following topics: Notification of change in Patient/Resident Health Status; Abuse, Neglect, Misappropriation, Exploitation. Was signed by MA A. In-service initiated [DATE] reflected the Nurses and MAs were in-serviced by the Interim DON and ADON on the following: PCC Alert on Vitals (When entering vitals in PCC and you receive an alert, you are to follow the instructions in the alert-notification of alert to physician; CMAs should report all alerts to their nurse and the nurse will take the appropriate action if notification to physician is required.) (continued on next page)

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