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	01/08/2026

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan consistent with resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #10) of 3 residents reviewed for comprehensive care plans.The facility failed to include Resident #10's tramadol pain medication in her care plan dated 11/20/25.This failure could lead to residents not receiving needed care and/or receiving improper care/treatment.Findings Included:Record review of Resident #10's admission revealed an [AGE] year-old female admitted on [DATE] and re-admitted on [DATE] with diagnoses that included, but were not limited to, heart failure, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A record review of Resident #10's MDS, completed on 12/22/25, revealed a BIMS score of 99 A BIMS score of 99 indicates that the exam could not be completed. Resident #10 is coded as receiving PRN pain medications.Record review of Resident #10's care plan with last revision date of 11/10/25 revealed no mention of pain medication or having pain-related issues. Record review of Resident #10 order summary dated 10/26/25 revealed the following order with an order start date of 12/01/25:Tramadol HCl Oral Tablet 50 MG (give 1 tablet by mouth every 6 hours as needed for pain). During an interview on 1/08/2026, at 11:12 AM with Resident #10. Resident #10 could not recall which medications she received at the facility and had difficulty answering the questions.During an interview on 01/08/ 2026 at 2:28 PM, The LPN stated she does not handle care plans. The LPN stated the resident's pain should have been documented in the care plan. The LPN stated if Resident #10's care plan was not updated; Resident #10 could receive incorrect treatment. During an interview on 01/08/2026 at 2:42 PM, LVN A stated RNs are responsible for the initial care plan. LVN A stated if Resident #10 was in pain, it should be in the care plan. LVN A stated if the care plan was incorrect, Resident #10 would not have up-to-date information about their care. The LVN stated this could result in Resident #10 receiving the wrong treatment. LVN A stated if any information in the care plan is incorrect, she will contact the provider. LVN A stated she does not update the care plan. During an interview on 01/ 08/2026 at 3:30 PM, The DON stated they currently do not have an MDS coordinator and that a corporate nurse was assisting until one was hired. DON stated LVN B was the last to assist with the MDS duties. DON stated that Resident #10 should have been care-planned for pain. DON stated if the care plan was not up to date, then Resident #10 could not get the right treatment and become sedated or injured. During an interview on 01/08/2026 at 2:42 PM, LVN B stated that she was assisting the facility with its care plans until 12/23/2025. LVN B. stated that PRN pain medication was not typically included in the care plan. LVN B stated that Resident #10 should have had pain listed in her care plan. LVN B stated she was not the one who updates care plans. LVN B stated that nurses are responsible for updating residents' care plans. LVN B stated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that if care plans are not updated, residents may receive insufficient care. During an interview on 01/ 08/2026 at 4:11 PM, CNA stated she does not enter anything into the care plan, but if there are changes, she will notify a nurse. CNA stated it was important for the care plan to be up to date because if it was not, residents may not receive appropriate care. CNA stated that a resident could get injured if the care plan was not updated. During an interview on 01/ 08/2026 at 4:20 PM, the ADM stated that all nurses can update residents' care plans and should do so when there was a change. ADM stated that Resident #10 should have been care-planned for pain. ADM stated that because Resident #10 was prescribed Tramadol, Resident #10 should have been care-planned for pain. ADM stated that if care plans are not up to date, a resident could receive incorrect care or be injured. Record review of facility policy titled Comprehensive Care-Planning that was not dated revealed the following: The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following -The services that are to be furnished to attain or maintain the resident's highest practicable physical,mental, and psychosocial well-being.Each resident will have a person-centered comprehensive care plan developed and implemented to meet hisother preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.