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	02/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents or obtain them for 1 of 5 (R#1) residents reviewed for medication administration. MA A failed to accurately administer R#1's p.m. medications on 02/11/26. R#1 was observed with 4 medications on her face. This failure could place residents at risk of not accurately receiving their medications, which could result in a change in condition. Record review of R#1's admission record, dated 02/13/26, reflected she was admitted to the facility on [DATE] and discharged from the facility on 02/11/26. She had medical diagnoses including displaced bimalleolar fracture of right lower leg (a serious, unstable injury involving fractures of both the medial malleolus (inner ankle) and lateral malleolus (outer ankle/fibula), lack of coordination, need for assistance with personal care, muscle wasting and atrophy, unsteadiness on feet, epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain), dementia (a decline in mental ability severe enough to interfere with daily life, hypertension (high blood pressure), chronic congestive heart failure and chronic kidney disease. Record review of R#1's quarterly MDS, dated [DATE], reflected she had a 15/15 BIMS, which indicated she was cognitively intact. She also took antidepressant, anticoagulant, opioid, and anticonvulsant medications. She had no s/s of swallowing disorders. Record review of R#1's care plan, revised 12/17/25, reflected she had impaired cognitive function and thought processes, impaired cardiovascular status, and impaired neurological status. She also experienced adverse medication effects and drug related complications and required monitoring for side effects.Record review of R#1's order summary report, dated 02/13/26, reflected, Give 5mg Apixaban oral tablet by mouth two times a day for preventative ordered and started on 12/13/ 25 Give one 500mg Levetiracetam oral tablet two times a day for seizures ordered and started 12/13/25 Give one 500mg Methocarbamol oral tablet by mouth every 6 hours for muscle spasms ordered and started 12/13/25 Give one 25mg Metoprolol Tartrate oral tablet my mouth two times a day for elevated blood pressure ordered and started 12/13/25 Give one 50mg Sertraline HCl oral tablet by mouth one time a day for depression ordered and started 12/13/25Record review of R#1's MAR/TAR for February 2026 reflected MA A documented he orally administered Sertraline MCl 50mg, Apixaban 5mg, Levetiracetam 500mg and Metoprolol Tartrate 25mg on 02/11/26 in the p.m . to R#1. MA A also documented that he orally administered Methocarbamol 500mg to R#1 on 02/11/26 at 5:00 p.m. Record review of R#1's progress notes dated 02/11/26 at 6:51 p.m., written by LVN B reflected, This lvn was notified during shift change 1815 (6:15 p.m.) that resident was not responding, this lvn assessed resident, res had drool and her pm medication was on her face, res would start to answer questions but unable to finish complete thought, this lvn called 911 at 1820 (6:20 p.m.), EMS arrived at 1830 (6:30 p.m.), transporting to hospital for eval and treatment, left facility at 1845 (6:45 p.m.). This lvn notified NP, administrator, DON and daughter. During an observation of R#1's room on 02/13/26 (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 10:31 a.m., R#1 was not in her room. During an interview with the BOM on 02/13/26 at 10:32 a.m., she stated R#1 was sent to the hospital on the night of 02/11/26 due to respiratory issues. During an interview with LVN C on 02/13/26 at 2:30 p.m., she stated MAs and nurses administered residents' medications according to physician's orders. She stated MAs and nurses were required to observe residents orally take their medications. She stated there was no one who oversaw and ensured MAs and nurses observed residents orally take their medications. She stated it was important to observe residents orally take their medications and, To make sure residents swallowed the medications or was having trouble swallowing medications or medication was left behind. To make sure to document medication was administered correctly. Residents could be at risk of not receiving their medication, which could hinder their treatment. During an interview with LVN B on 02/13/26 at 2:44 p.m., she stated MAs and nurses administered residents' medications according to physician's orders. She stated MAs and nurses were required to observe, oversee and ensure residents orally take their medications successfully. She stated she observed four medications on R#1's face on 02/11/26 and notified the DON, who identified and provided the medications to EMS when they arrived to take R#1. She stated she did not know what medications she observed and that the DON identified were on R#1's face because she did not administer the medications to R#1, but she believed one of the medications was Metoprolol. She stated MA A administered medications to R#1. She stated it was important to observe residents orally take their medications and, Because it could be a choking hazard and because they might not get the medication. She stated she did not receive any in-services after R#1 was sent to the hospital on [DATE]. During an interview with MA A on 02/13/26 at 3:05 p.m., he stated MAs and nurses administered residents' medications according to physician's orders, facility's policy and procedures, and federal regulations. He stated MAs and nurses were required to observe residents orally take their medications. He stated he verified residents orally took their medications by talking to residents after administering their medications. He stated he observed R#1 take her medications by talking to her after administering the medications to her on 02/11/26 in the p.m. He stated it was important to observe residents orally take their medications, and, To make sure residents are not spitting them out and they are following doctor's orders. Residents could be at risk of getting sick or sicker depending on what the medications are for, and they could choke. He stated the ADM in training in-serviced him on s/s of sedation and resident rights after R#1 was sent to the hospital on [DATE]. He stated he was not in-serviced on medication administration after R#1 was sent to the hospital on [DATE]. During an interview with the Regional Nurse on 02/13/26 at 3:31 p.m., she stated the DON was out of the facility. She stated MAs and nurses administered residents' medications according to physician's orders. She stated MAs and nurses were required to observe residents take their medications and ensure they took successfully took them. She stated she did not know what medications the DON identified R#1 had on her face and provided to EMS on 02/11/26. She stated she did not know if staff started receiving in-services on medication administration before 02/13/26. She stated it was important to observe residents orally take their medications and, Well you want residents to get their medication and meet their levels. Residents could be at risk of not being stable depending on their condition. It's important to make sure residents took their medication. Residents could be at risk depending on residents condition and the medication the resident was required to take.During an interview with the ADM on 02/13/26 at 3:41 p.m. she stated MAs and nurses administered residents medications according to physician's orders. She stated MAs and nurses must observe residents successfully take their medications. She stated she knew it was important to observe residents successfully take their medications and said, You must make sure residents took their medications because it is based on their physician's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. She stated she did not in-service staff on medication administration after staff sent R#1 to the hospital on [DATE] and said, Because I did not think that was the problem. She stated she observed R#1 was drooling and had four pieces of medication on her face. She stated she did not know what medications she observed on R#1's face on 02/11/26 before EMS arrived and took R#1 to the hospital, but she believed one of the medications was a blue pill. She stated R#1 was alert and oriented.During an interview with the ADON on 02/13/26 at 3:51 p.m., she stated MAs and nurses administered and observed residents take their medications successfully. She stated it was important to monitor residents orally take their medications and, To verify it was taken and what was actually take. Residents could be at risk of a missed dose.Review of the facility's medication administration and general guidelines policy, 2025, reflected, Policy: Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. Procedure: 1. Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or otherpersonnel authorized by state laws and regulations to administer medications.2. Medications are administered in accordance with written orders of the attending physician.Checklist for completing proper steps in the administration of medications:.Observes the resident take the medications.