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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lampasas Nursing and Rehabilitation Center	611 N. Broad 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive assessment accurately reflected the resident's status for 1 (Resident #1) of 6 residents reviewed for accuracy of assessments. The facility failed to ensure the MDS assessment dated [DATE] was updated to reflect all of Resident #1's current functional abilities. This failure could place residents at risk of inaccurate assessments and not receiving appropriate care according to their status.Findings included: Record review of Resident #1's faces sheet dated 06/17/26 reflected an [AGE] year old male initially admitted to the facility on [DATE] with a readmission of 04/15/26 and had diagnosis that included unspecified severe protein calorie malnutrition (condition that occurs when the body does not receive enough protein and calories to maintain proper health), hypertensive urgency (severely elevated blood pressure), type 2 diabetes mellitus (chronic condition characterized by insulin resistance and high blood sugar levels) with hyperglycemia (high blood sugar levels) , and age related physical debility. Record review of Resident #1's admission MDS assessment dated [DATE] reflected that the following areas were not completed and marked with a dash (-).Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed.Tub/shower transfer: The ability to get in and out of a tub/shower.Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.The MDS assessment reflected all sections were completed and signed for by CRS A. Record review of Resident #1's comprehensive care plan initiated 4/24/26 and last revised 06/17/26 reflected a focus of The resident has an ADL Self Care Performance Deficit with interventions that included: Bathing: requires staff x1 for assistanceDate Initiated: 04/24/2026 Bed Mobility: supervision as neededDate Initiated: 04/24/2026 Discuss with resident/family/POA care any concerns related to loss ofindependence, decline in function.Date Initiated: 04/24/2026 Eating: supervision as neededDate Initiated: 04/24/2026The care plan did not reflect other areas of functional abilities such as personal hygiene, shower transfers, or dressing assistance required. During an interview on 06/17/26 at 03:50 PM with CRS A, she stated she assists with the completion of MDS assessments in the facility. She stated she gathers information from a number of sources to include nursing, therapy, the resident or family member in order to complete the MDS assessment. She stated a dash (-) is used when they don't have the information and its used per the RAI. She stated that she was unable to complete Resident #1's MDS assessment because she did not have the baseline care plan completed by nursing staff. She stated she is aware of the different methods of obtaining the information for the assessment and that a (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident or RP interview is also sufficient when trying to determine certain functional abilities, she stated the interviews were not attempted. CRS A stated the MDS assessment is used to help with the comprehensive care plan and if its not completed it had the potential to result in an incomplete care plan and the care provided to residents could not be accurate. During an interview on 06/17/26 at 04:15 PM with the DON she stated that it was her expectation that MDS assessments were accurate and complete. She stated she was not entirely sure on what the protocol was on submitting an MDS assessment or the timeframes for submitting. She stated that for section GG of the MDS assessment functional abilities that information can be used based on prior level of functioning if they had been a resident and are coming back from a hospitalization if they have the history, can interview the resident or RP to obtain the information, or that hospital records can also be used to determine abilities while they were admitted at the hospital. The DON stated that the MDS assessment will go on to help build the plan of care. She stated she was not sure what was followed for the MDS assessments if it was the RAI or if there was an internal policy, but stated state regulations should be followed. The DON stated the MDS assessment guides care; she said if it was not complete they would not have the most updated care which could potentially affect a residents progress and ability to maintain or progress in their level of function. During an interview on 06/17/26 at 04:44 PM with the ADM she stated with MDS assessments there should be no errors on the document, and it should be completed within the 7 days required. She went on to say, there is no room for errors when you have all the information provided to you. She stated the IDT (interdisciplinary team) helped provide all the necessary information to the staff completing the MDS assessment. She stated that apart from the IDT information provided, information needed for the MDS assessment could be obtained through clinical documents from the hospital, updated documents, the face sheet, hospice, she stated a resident or RP interview can also be done to get that information. The ADM stated the facility follows both the RAI manual and the facility policy. She stated based on the policy it refers staff back to the RAI. The ADM stated the MDS affects the way staff care for residents and if it were done wrong, they would be caring for them the wrong way. She stated the DON is ultimately responsible for ensuring the MDS assessments are completed timely and accurately. Review of the facility Resident Assessment- Nursing Policy and Procedure Manual 2003 reflected:A comprehensive assessment will be completed within 14 days of admission and annually on each resident. The facility will utilize the Resident Assessment Instrument (RAI).The assessment will include at least the following: physical and mental functional status.RAI assessments must be conducted within 14 days after the date of admission.The results of the assessment are used to develop, review, and revise the residents comprehensive plan of care.Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Record review of the CMS Final MDS 3.0 RAI Manual version 1.20.1 October 2025 reflected:admission: The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay. Additionally, an OBRA admission assessment (A0310A = 1) is required for a new resident and, under some circumstances, a returning resident and must be completed by the end of day 14. Please refer to Section 2.6 of this Manual for additional information about the OBRA admission assessment. o For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functional assessment. o For an OBRA admission assessment, code the resident's usual performance during first 3 days of their stay starting with the date in A1600, Entry Date.Assessment of the GG self-care and mobility items is based on the resident's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking might be assessed for a resident who did/does/will use a wheelchair as their primary mode of mobility, stair activities might be assessed for a resident not routinely accessing stairs).OBRA/Interim: The Interim Payment Assessment (IPA) (A0310B = 08) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM (payment driven payment model) classification. OBRA assessments (A0310A = 01 - 06) are required for residents in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual. For Section GG on the IPA Interim Payment Assessment (IPA) or an OBRA assessment, providers will use the same 6-point scale and activity not attempted codes to assess the resident's usual functional performance during the 3-day assessment period.Coding Instructions:When coding the resident's usual performance, use the six-point scale, or use one of the four activity was not attempted codes to specify the reason why an activity was not attempted.A dash (-) indicates No information. CMS expects dash use to be a rare occurrence.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for one (Resident #1) of six residents reviewed for baseline care plans, in that: Resident #1 did not have a baseline care plan developed in 48 hours of his admission on [DATE]. This failure had the potential to cause residents to not be provided needed care to prevent injuries, feelings of helplessness and a diminished quality of life. Findings Include: Record review of Resident #1's faces sheet dated 06/17/26 reflected an [AGE] year old male initially admitted to the facility on [DATE] with a readmission of 04/15/26 and had diagnosis that included unspecified severe protein calorie malnutrition (condition that occurs when the body does not receive enough protein and calories to maintain proper health), hypertensive urgency (severely elevated blood pressure), type 2 diabetes mellitus (chronic condition characterized by insulin resistance and high blood sugar levels) with hyperglycemia (high blood sugar levels) , and age related physical debility. Record review of Resident #1's comprehensive care plan reflected it was initiated 4/24/26 and last revised 06/17/26. Record review of Resident #1's medical record reflected there was no available baseline care plan completed within 48 hours of Resident #1's most recent admission on [DATE]. During an interview on 06/17/26 at 03:50 PM with CRS A, she stated she assists with the completion of MDS assessments in the facility. She stated she gathers information from a number of sources to include nursing, therapy, the resident or family member in order to complete the MDS assessment. She stated a dash (-) is used when they don't have the information and its used per the RAI. She stated that she was unable to complete Resident #1's MDS assessment because she did not have the baseline care plan completed by nursing staff. During an interview on 06/17/26 at 04:15 PM with the DON she stated that from what she could see the baseline care plan for Resident #1 was not completed and she could not locate the assessment which had been required within 48 hours of admission. The DON stated the purpose of the baseline care plan is to make sure everyone is on the same page regarding the care. She stated that a negative outcome of not having a baseline care plan available within 48 hours of admission was the staff would not know what needs to be done to care for the resident. During an interview on 06/17/26 at 04:44 PM with the ADM she stated it was her expectation and policy that baseline care plans were to be completed within 48 hours of a resident admission, and she stated it was the DONs responsibility to ensure they were completed. She stated the purpose of the baseline care plan is to ensure they are treating the resident per their diagnosis. She stated a negative outcome of not having it completed in the timeframe required would be it had the potential to lead to an injury or result in the resident ending back in the hospital since nurses wouldn't know how to treat them. Review of the facility undated Base Line Care Plans policy reflected:Completion and implementation of the baseline care plan within 48 hours of a residents admission is intended to promote continuity of care and communication among nursing home staff, increases resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The baseline care plan will-Be developed within 48 hours of a residents admission.Include the minimum healthcare information necessary to properly care for a resident including but not limited to-initial goals based on admission ordersphysician ordersdietary orderstherapy servicessocial servicesPASARR recommendations if applicable