STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Ltc Partners Inc	1621 Butler Dimmitt, TX 79027

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** 48161 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights 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 and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 5 residents reviewed for care plans. The facility failed to develop a comprehensive person-centered care plan based on assessed needs to address Resident #1's bipolar disorder, anxiety and depression and their interventions. This failure could place residents at risk of not receiving desired and necessary care and treatment. Findings Included: Record review of Resident #1's admission record dated 03/18/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, bipolar disorder current episode depressed, moderate, anxiety disorder and major depressive disorder, recurrent. Record review of Resident #1's quarterly MDS completed on 03/07/2025 revealed a BIMS score of 12 out of 15 indicating moderate cognitive impairment. Section I of the MDS indicated Resident #1 had active diagnoses of anxiety disorder, depression, and bipolar disorder. Record review of Resident #1's care plan, revised on 2/24/2025, had no mention of Resident #1's bipolar disorder, depression or anxiety diagnosis with no goals or interventions related to the diagnoses. Record review of Resident #1's active physician orders dated 02/27/2025 revealed the following medication orders: An order dated 02/27/2025 for Xanax Oral Tablet 0.25 MG (Alprazolam)-Give 1 tablet by mouth every 6 hours related to anxiety. disorder. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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	An order dated 02/27/2025 for Aripiprazole Oral Tablet 10 MG -Give 1 tablet by mouth at bedtime related to Bipolar disorder, current episode depressed moderate, and major depressive disorder, recurrent. Record review of Resident #1's medication administration record for February 2025 revealed Resident #1 received Aripiprazole oral tablet 10 mg on 02/27/2025 and 02/28/2025. Resident #1 received Xanax oral tablet .25 mg every six hours on 02/27/2025 and 02/28/2025. Record review of Resident #1's medication administration record for March 2025 revealed Resident #1 received Aripiprazole oral tablet 10 mg on 03/01/2025 through 03/17/2025. Resident #1 received Xanax oral tablet .25 mg on 03/01/2025 through 03/17/2025. During an observation and interview on 03/18/2025 at 5:15 AM, Resident #1 was in her room sitting on her bed watching tv. Resident #1 stated that she receives medication for her anxiety and depression. Resident #1 said she was offered counseling for her anxiety but said she declined it. During an interview on 03/18/2025 at 10:00 AM, the DON stated that Resident #1's bipolar disorder and anxiety diagnosis should have been put in her care plan. The DON stated a possible negative outcome for not having information in the care plan would be that staff would not be aware of what the resident needs. The DON stated that it was the nursing staff and MDS Coordinator's responsibility to ensure the care plans were updated and completed. During an interview on 03/18/2025 at 10:05 AM, the ADON stated it was nursing staff's responsibility to ensure care plans were completed and Resident #1's diagnoses and medication should have been put in the care plan. A possible negative outcome for not having that information in the care plan would be staff would not know the resident's needs. During a telephone interview on 03/18/2025 at 10:11 AM, the MDS LVN stated that it was her responsibility to make sure care plans were up to date. The MDS LVN stated that Resident #1's care plan must have been missed with updating her diagnoses and medication regimen. The MDS LVN stated that a possible negative outcome for not having an updated care plan would be that staff would not be aware of the resident's diagnosis and interventions. Record review of facility policy titled 'Comprehensive Care plans' revealed the following: It is the policy of this facility to develop and implement a comprehensive, person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will describe at the minimum, the following: .The services that are to be furnished to attain or maintain the resident's highest physical, mental, and psychosocial well-being .