

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/24/2025
NAME OF PROVIDER OR SUPPLIER  Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  900 College Ave Borger, TX 79007	

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 0657  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.  (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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 of 9 residents (Resident #1) reviewed for care plan timing. The comprehensive care plan for Resident #1 was not developed within 7 days after the completion of the comprehensive assessment. The failure could place residents at risk of receiving care that is not person-centered and/or is inadequate to meet the needs identified during the comprehensive assessment. Findings Included: Record review of Resident #1's face sheet, dated 11/24/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia severe with mood disturbances (cognitive decline in memory, reasoning, and the ability to perform daily activities, mood disturbances, which may include symptoms such as depression, anxiety, or irritability), major depressive disorder, type 2 diabetes mellitus without complication, hypertension (elevated blood pressure), generalized anxiety disorder. Record review of Resident #1's annual MDS dated [DATE] revealed a BIMS of 12 which indicated moderate cognitive impairment. Record review of Resident #1's MDS tab in the EHR revealed the following:A Quarterly MDS dated [DATE] Record review of Resident #1's care plan revealed that there was no update or revision to Resident #1's care plan after the completion of the MDS assessment was completed on 10/31/2025. Record review of Resident #1's care plan tab in the HER revealed the following:A care plan with a start date of 09/17/2025, completion date of 09/17/2025. During an interview on 11/24/2025 at 2:24pm with MDS LVN stated it was her responsibility to ensure care plans were timed correctly with MDS assessments. MDS LVN stated she followed the RAI manual as well as facility policies when she was performing care plans and MDS assessments. MDS LVN stated if the care plan was not updated according to the most recent assessments the resident would not receive the correct care. During an interview on 11/24/2025 at 3:39pm with DON stated, the care plan should have be updated within 7 days of completion of the MDS performed on 10/31/2025. DON stated a negative outcome for not updating the care plan does not reflect the needs of the residents, it leads to inaccurate care plans and the residents not receiving the required care it takes to take care of the resident as best as we can. DON stated, It was a team effort to ensure that care plans are revised and updated timely. Record review of the facility's undated policy titled, Comprehensive Care Planning revealed, in part, 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 resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.Care planning drives the type of care and services that a resident receives.When developing the comprehensive are plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.A comprehensive care plan will be-Developed within 7 days after completion of the comprehensive assessment.The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.</p>		