

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Caraday of Lampasas		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E Ave J 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50360</p> <p>Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 (Resident #20) of 5 residents reviewed for comprehensive care plans.</p> <p>Record Review of Resident #20's comprehensive care plan did not reflect that Resident #20 had a blister-like lesion to the mid portion of her bottom lip that was purplish-blue in color of unknown origin date per medical record review . The wound was approximately two centimeters in size.</p> <p>This deficient practice could place residents at risk for receiving improper care and services due to inaccurate care plans.</p> <p>Findings included:</p> <p>Observation of Resident #20 first occurred 11/05/2024 at 9:00 am upon entrance to the facility. She was sitting in the lobby. Resident #20 had a blister-like lesion to the mid portion of her bottom lip that was purplish-blue in color. The wound was approximately two centimeters in size. The second observation took place in the Dining Room at 12:30 PM on 11/06/2024 Resident #20 was observed being assisted to eat by the facility staff. The lesion did not appear to affect her nutritional or fluid intake.</p> <p>A record review of Resident #20's face sheet for admitted [DATE] reflected an [AGE] year-old female. Resident #20's diagnosis Unspecified Dementia (a general term for a decline in mental abilities that affects a person's daily life), Unspecified Severity, without Behavioral Disturbance, Mood Disturbance, and Anxiety.</p> <p>A record review of Resident #20's Initial MDS assessment, dated 08/31/2024, reflected the resident had a BIMS score of 0, which indicated severe cognitive impairment. Resident #20's Initial MDS reflected Resident #20's current diagnosis of Diabetes Mellitus (a chronic disease that occurs when the body cannot properly regulate blood sugar levels). Documentation of the lesion to the bottom lip was not recorded on the MDS.</p> <p>A record review of Resident #20's care plan, dated 10/04/2024, did not reflect or address Resident #20's lesion to the middle portion of the lower lip.</p> <p>(continued on next page)</p>

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #20's Nursing Notes dated 10/24/2024 and 10/25/2024 reflected that Resident #20 was on an antibiotic for a bacterial infection of the lip lesion. Also, the medical record contained an Infection Control Surveillance Form dated 10/18/2024. There was documentation on the form of a skin/soft tissue infection that contained pus at wound, skin, or tissue site, redness at affected site, swelling at affected site, and tenderness or pain at affected site with no location documented. Review of skin assessments of last 3 months reveal no documentation of the lesion. There were no wound care records to review.</p> <p>During an interview with the Social Worker on 11/05/2024 at 3:20pm, who stated that the resident had had this lesion since admission, and it was caused by a protruding front tooth. According to the Social Worker, early in the Resident's stay, the resident's responsible party was not supportive of having the tooth removed. Later, he did give consent and the Social Worker planned with the dentist to have one of the front teeth removed; however, the dentist declined to remove the other front tooth because it was a healthy tooth. In another interview on 11/06/2024 at 9:20 am, the Social Worker stated the wound had gotten better and had gotten worse over time. She reported that it was a result of an assault the resident suffered at another facility prior to her admission to the facility She reported noting that the resident had been observed to nibble at the site from time to time. the Social Worker confirmed that she had not entered any documentation in the medical record regarding her conversations with the dentist.</p> <p>During an interview with the DON on 11/06/2024 at 9:05 am, she reported the wound care team stated there was nothing to treat. She confirmed the lesion had been present since admission. Additionally, she stated the lesion had not hindered the resident's ability to take in nourishments and fluids and there were no non-verbal signs of pain at the site unless direct pressure was exerted upon the lesion.</p> <p>An interview was conducted with the DON on 11/07/2024 at approximately 2:00pm. The DON reported she was shocked that the lesion did not appear on the Care Plan and that the IDT was responsible for making sure all Care Plans are accurate. She stated not having the lesion on the care plan would put the resident at risk for not receiving appropriate care and treatment.</p> <p>Interview at 2:00pm on 11/07/2024, the ADM stated he was not aware that the lesion was not addressed on the Care Plan. It was his expectation that it should be to ensure the resident received appropriate care.</p> <p>A record review of the facility's Care Plans, Comprehensive Person-Centered policy, dated revised March 2022, reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p>		