

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 12/22/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #3 and Resident #4) of 5 residents reviewed for infection control practices, in that: The facility failed to ensure LVN B sanitized blood pressure monitor in between Resident #3 and Resident #4 while obtaining blood pressure. This failure could place residents at risk for cross-contamination and infections. Findings included: Resident #3 Review of Resident #3's face sheet dated 12/22/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis of hypertension. Review of Resident #3's initial MDS assessment, dated 10/03/25 reflected a BIMS score of 15, indicating his cognition was intact. Review of Resident #3's care plan dated 09/27/25 had not reflected his diagnosis of hypertension. Review of Resident #3's medication order reflected: Lisinopril Oral Tablet 30 MG (Lisinopril): Give 1 tablet by mouth one time a day for hypertension Hold for SBP<110 OR DBP<60 OR HR<60.-Start date: 09/27/25. Resident #4 Review of Resident #4's face sheet dated 12/22/25 reflected a [AGE] year-old male initially admitted to the facility on [DATE] and re admitted on [DATE] with the diagnosis of hypertension. Review of Resident #4's quarterly MDS assessment, dated 11/28/25, reflected a BIMS score of 15, indicating his cognition was intact. Review of Resident #4's care plan dated 08/4/15 had not reflected his diagnosis of hypertension. Review of Resident #4's physician's order reflected: Lisinopril Oral Tablet 10 MG (Lisinopril): Give 1 tablet by mouth one time a day for HTN: Start date 07/18/25. During an observation on 12/22/25 at 10:15 a.m., LVN B measured the blood pressure of Resident #3 using a blood pressure monitor without sanitizing the device. After administering medications to Resident #3, she proceeded to Resident #4 and used the same blood pressure monitor without sanitizing it between residents. LVN B did not sanitize the monitor after using it on Resident #4 until the investigator brought it to her attention. During an interview on 12/22/25 at 10:35 a.m., LVN B stated that sanitizing blood pressure cuffs between residents was important, but she forgot to do so because she was in a rush. LVN B stated that following infection control protocols was essential to minimize the spread of disease among residents. She reported receiving infection control training the previous month but stated there had been no in-service training specifically addressing the sanitization of medical equipment. During an interview on 12/22/25 at 11:35 a.m., the ADM stated that, in accordance with the facility's infection control protocol, all medical equipment in use, including blood pressure cuffs, must be sanitized immediately after use on residents. He explained that this practice was one of the facility's measures to minimize the spread of infectious diseases and that staff are trained in these procedures. The ADM further stated he did not know the exact date staff last received in-service training on infection control, as he was new to the facility. Review of the in-service records from 10/01/25 to 12/22/25 revealed there were no in services specifically on sanitizing medical equipment in between the residents. Review of facility's undated policy Fundamentals of Infection Control Precautions reflected: . Resident care equipment and articles: Non-invasive resident care equipment is cleaned daily or as needed between use by the nursing assistant.</p>		