STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676473	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Lampasas	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)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49048 Based on observations, interviews, and record reviews, the facility failed to provide nutrition and hydration care and services for two of three residents (Resident # 24 and Resident #18), consistent with the resident's comprehensive care plan. The facility failed to provide sufficient fluids for two of three residents to prevent dehydration and infections. This deficient practice placed the residents at risk for increased confusion, lethargy, increased urinary tract infections, kidney issues, excessive thirst, dry skin, decline in status, pain, illness, hospitalization and affects their psychosocial wellbeing. Findings included: Review of the undated face sheet and undated care plan for Resident #24 reflected a [AGE] year-old male admitted on [DATE]. His diagnoses include Huntington's Disease (a brain disorder that causes the nerve cells in the brain to breakdown and die), adjustment disorder with Mixed Anxiety and Depressed Mood (a person experiences mixed symptoms of adjustment disorder with Anxiety and Adjustment Disorder with Depressed Mood), Other Lack of Coordination (the brains inability to coordinate muscle movements), Dysphagia (difficulty swallowing), Unspecified Protein-Calorie Malnutrition (inadequate intake of food). Observation on 11/06/2024 at 11:25 AM, Resident #24 was sitting in wheelchair in dining area prior to lunch. No fluids were offered to resident before he was assisted with feeding. The resident was unable to speak. The resident was observed with dry lips and dry skin on his face. Observation on 11/07/2024 at 8:50 AM, Resident #24 was sitting in wheelchair in lobby. The resident was observed with dry, cracked lips, a dried, crusty fluid around both eyes, dry skin on his face. There were no fluids observed near the resident. Observations on 11/07/2024 at 10:15 AM, 10:53 AM, 11:10 AM, 2:24 PM and 3:40 PM revealed that Resident #24 was sitting in wheelchair in the lobby. Resident #24's face remained dry and appeared that his face was not washed since he woke up or after breakfast. There were no fluids observed near the resident, no cups with the resident's name, nor was staff observed offering fluids to the resident. Review of Resident #24's undated care plan reflected the following: (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 0692 Level of Harm - Actual harm Residents Affected - Few	Problem: The resident has a potential for fluid deficit related to poor intake. Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. The resident will be offered and encouraged to drink adequate fluids through the next review date. Interventions: 1) Educate the resident/family/caregivers on importance of fluid intake. 2) Encourage the resident to drink fluids of choice. 3)Ensure The resident has access to fluids whenever possible. 4) Invite the resident to activities that promote additional fluid intake. Offer drinks during one-to-one visits. Ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements. 5) Monitor/document/report PRN any signs and symptoms of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. 6)The resident needs assistance/encouragement/supervision to meet the daily requirements for fluid intake. Review of the face sheet for Resident #18 reflected a [AGE] year-old-male readmitted on [DATE]. His diagnoses include Down Syndrome (a genetic disorder when there is an extra copy of chromosome 21), anxiety disorder (excessive fear and anxiety that interferes with daily life), Restlessness and Agitation (feeling of intense distress or irritability), Major Depressive Disorder (affects how a person feels, thinks and acts), Shortness of Breath (not being able to breathe normally or deeply enough). Observation on 11/06/2024 at 8:43 AM, revealed the resident in his room, sitting in wheelchair watching television. There were no cups or water bottles in the resident's room. Resident is unable to communicate. Observations on 11/07/2024 at 10:15 AM, 10:53 AM, 11:10 AM, 2:24 PM and 3:40 PM revealed that Resident #18 was sitting in wheelchair in the lobby. There were no fluids observed near the resident, no cups with the resident's name, nor was staff observed offering fluids to the resident. Review of Resident #18's progress note 11/4/2024 at 10:00 PM revealed, When administering evening mediations writer noticed resident was lethargic and very pale. Resident was only alert to painful stimuli at this time. Vitals were 99/65, 110, 22 resp. 94% on RA, 97.4. Call placed to on call. Order given to start IV and administer bolus of NS. 22G to Right hand was established and IV fluids started. On-call also stated to order stat CBC, CMP, BNP. Family was notified and decided they would like resident sent to ER for evaluation. Resident returned to facility at 1:00 AM with DX of hypotension, bladder infection, dehydration with new order for Benzonatate 100 MG capsule by mouth three times a day as needed for cough. Vitals at return were 110/75, 90, 19, 99%RA, 98.0. Review of Resident #18's undated care plan reflected the following: Problem: The resident has a potential for fluid deficit. Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interventions: 1) Administer medications as ordered. Monitor/document for side effects and effectiveness. 2) Educate the resident/family/caregivers on importance of fluid intake. 3) Invite the resident to activities that promote additional fluid intake. Offer drinks during one-to-one visits. Ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements. 4) Monitor and document intake and output as per facility policy. 5) Monitor/document/report PRN any signs or symptoms of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. 6) Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow-up as indicated. Record Review of Resident #18's physicians orders, progress notes, assessments, and miscellaneous documents in Point Click Care (electronic health record) revealed that fluid intake was not tracked prior to and after Resident #18's trip to the emergency roiagnom on [DATE]. Observations on 11/5/2024, 11/6/2024 and 11/7/2024 between 8:30 AM and 3:00 PM revealed that Resident #24 and Resident #18 did not have fluids readily available, nor were staff observed offering them fluids. Interview on 11/7/2024 at 10:18 AM with CNA-A, who stated hydration was being passed at that time and pointed down the hallway towards the cart. She could not identify signs and symptoms of dehydration. She was not able to provide example of how Resident #24 and Resident #18, who are both non-communicative, would demonstrate thirst or ask for fluids. Interview on 11/7/2024 at 3:49 PM with AD, who stated Hydration was on the activities calendar. She said she was informed by her predecessor that Hydration should have been on the calendar, although she disagreed. She stated she and her assistant take the hydration cart around to residents. She stated hydration was supposed to be offered to residents once on each shift 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM. Interview on 11/7/2024 at 3:49 PM with CNA-B, who stated she had witnessed hydration being passed out on the night shift. Interview on 11/7/2024 at 3:57 PM with CNA-C, who stated, We have a hydration cart. The residents had their own water bottles/cups in their rooms, and we tried to fill them up. She identified signs and symptoms of dehydration as mouth looks dry, skin looks flushed, they might have trouble communicating or they might have a facial expression. Interview on 11/7/2024 at 4:12 PM with the DON, who stated that the AD and CNA-B passed water and ice to the residents at 10:00 AM and 2:00 PM. She stated they, generally in-service monthly on Hydration. She checked the in-service book, and the last Hydration in-service was conducted on 9/23/2024. She stated her expectation was that non-communicative residents receive the same level of hydration as other residents. She identified signs, symptoms and consequences of dehydration include dry mouth, making mouth gestures or smacking their lips, lack of tear production, incontinence, and skin issues. She stated Resident #24 was also on a medication that has a noted side effect of dehydration. Review of the facility policy titled, Hydration - Clinical Protocol, MED-PASS, revision date September 2017, reflected the following: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Assessment and Recognition: 1. The physician and staff will help define the individual's current hydration status (fluid and electrolyte balance or imbalances) a. The physician will distinguish various types of fluid and electrolyte imbalance (for example, hyponatremia, hypernatremia, pre-renal azotemia, etc.) from true dehydration (clinically significant loss of total body water). 2. The staff, with the physician's input, will identify and report to the physician individuals with signs and symptoms (for example, delirium, lethargy, increased thirst, etc.) or lab test results (for example, hypernatremia, azotemia, etc.) that might reflect existing fluid and electrolyte imbalance. 3. The physician and staff will identify significant risk for subsequent fluid and electrolyte imbalance; for example, individuals with prolonged vomiting, diarrhea, or fever, or who are taking diuretics and/or ACE inhibitors and who are not eating or drinking well. Cause Identification: 1. The physician will help identify the cause(s) of any existing fluid and electrolyte imbalance or help the staff document why the individual should not be tested or evaluated. a. A limited review for causes (for example, based on the clinical situation and a basic metabolic profile [BMP]) may be appropriate even if an extensive work-up is not. Treatment/Management: 1. The physician will manage significant fluid and electrolyte imbalance, and associated risks, appropriately and in a timely manner. a. Timeliness depends on the severity, nature, and causes of the fluid and electrolyte imbalance. b. For minor, uncomplicated fluid and electrolyte imbalance, oral rehydration may suffice. For more severe or complicated fluid and electrolyte imbalance, subcutaneous (hypodermoclysis) or intravenous hydration may be needed. c. Any medications that are contributing to fluid and electrolyte imbalance should be tapered or stopped (at least temporarily), or the physician should provide clinically valid documentation as to why they cannot or should not be changed, even temporarily. 2. The staff will provide supportive measures such as supplemental fluids and adjusting environmental temperature, where indicated. Monitoring and Follow-Up: 1. The physician and staff will monitor for the subsequent development, progression, or resolution of fluid and electrolyte imbalance in at-risk individuals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	a. For example, replacement may be adequate if the resident is clinically stable, not having delirium, aiding at least every 3-4 hours, and the urine specific gravity (where attainable) is less than 1.015. 2. The physician will adjust treatments based on specific information (lab results, level of consciousness, etc.) relevant to that individual. a. Oral replacement may be adequate if the patient is clinically stable, not having delirium, voiding at least every 3-4 hours, and the urine specific gravity (where attainable) is less than 1.015. b. Repeating the basic metabolic profile and/or serum osmolality can help track progress in correcting abnormalities.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50360 Based on Interview and Record Review, the facility failed to determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled (a system of recordkeeping that ensures an accurate inventory of medication by accounting for controlled medications that have been received, dispensed, administered, and/or, including the process of disposition). The documentation was incomplete on the controlled medications (narcotics) count logs for one of four medication carts reviewed. The facility failed to ensure all controlled medications (narcotics) were accurately reconciled at the start and end of each shift on 11/01/2024. This failure could place residents at risk of misappropriation by drug diversion and could result in diminished health and well-being. The findings included: A Record Review On 11/06/2024 at 2:20pm, of the facility change of shift narcotic counts revealed missing documentation for 11/1/2024 for the 6am-2pm shift, the 2pm-10pm shift, and the 10pm-6am shifts. The missing documentation was observed on the Med Cart labeled Hall B/C Medication cart. During an Interview with LVN D on 11/05/2024 at approximately 8:30am, she affirmed that controlled medications (narcotics) were to be counted at every shift change. During an Interview with MDS Nurse on 11/07/2024 at 2:36pm who stated she did assist with giving medications at times. MDS Nurse confirm ed there was to be a narcotic count at the change of each shift. When asked how she knew she was to count narcotics with the off-going and on-coming nurse at shift change, she replied, it's a given. During an interview with the DON and the Corporate Nurse on 11/07/2024, they affirmed that there was no policy that specifically require d and define d the parameters for change of shift narcotic count. There was also no printed material regarding the change of shift count in new employee orientation; however, they did share the Drug Discrepancies, Loss, or Diversion document from the contracted Pharmacy provider. The document stated: The facility will comply with all federal, state, and local laws as it pertains to dangerous drugs and controlled substances. The facility must have a system that records receipt, usage, and disposition of all controlled substances in sufficient detail that permits an accurate reconciliation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49048 Based on observation, interviews and record review, the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for food and nutrition services. The facility failed to ensure the green beans in the refrigerator were discarded after the handwritten discard date and that food temperatures were tested in a manner that prevented food contamination. This failure places the residents at risk for being served food past the expiration date and foodborne illness from eating contaminated food. Findings included: Observation on 11/5/2024 at 9:01AM revealed an opened, white, plastic container with a label that read, [NAME] Beans 10/29 - 11/1. Interview on 11/5/2024 at 9:03AM with the DM, who stated the green beans should have been discarded 4 days ago. She said her expectation was that all items should have been clearly labeled with an opened on and discard by date. She stated she had routinely trained and reminded staff regarding the importance of having foods properly labeled and discarded by the discard date. Interview on 11/7/2024 at 4:30PM with the ADM, who stated his expectation was that the kitchen staff should have followed the policy regarding proper labeling and storage. Observation on 11/5/2024 at 11:58AM revealed while testing the food temperatures, DC allowed the thermometer to lay on top of the chicken strips. Observation on 11/5/2024 at 12:02PM revealed while testing the food temperatures, DC allowed the thermometer to lay on top of the broccoli pieces. Observation on 11/5/2024 at 12:06PM revealed while testing the food temperatures, DC allowed the bottom of the thermometer to touch the gravy. Interview on 11/5/2024 at 12:06PM with DC, who stated the food thermometer should not have touched the food when testing food temperature. Interview on 11/6/2024 at 11:09PM with the DM, who stated her expectation was that the food thermometers should not have touched the food when the food temperatures were tested , as it could have contaminated the food. Interview on 11/6/2024 at 11:25PM with the RD, who stated his expectation was that the thermometers should not have touched the food as it could have contaminated the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/7/2024 at 4:30pm with the ADM, who stated his expectation was that the kitchen staff should have tested the food temperature in a safe manner and avoided potential contamination of the food. Review of the facility policy titled Food Storage, revision date June 1, 2019, stated the following: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food stored according to the state, federal and US Food Codes and HACCP guidelines: 2. Refrigerators e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. Review of the facility policy titled Taking Temperatures, revision date June 1, 2019, does not address how food temperatures should have been tested without contaminating the food. The policy only what temperatures were acceptable, when reheating was required and when food should have been discarded. .