STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455889	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lily Springs Rehabilitation and Healthcare Center	901 Central Texas Expwy 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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and failed to protect and promote the rights of the residents for one of four residents (Residents #1) reviewed for resident rights. The facility failed ensure CNA A and CNA B identified themselves and explained or asked permission to perform a mechanical lift transfer and incontinent care for Resident #1 on 06/13/24. This failure led to Resident #1 exhibiting nonverbal signs of fear and/or pain including widened eyes, an open mouth, and facial grimacing during the procedure. This deficient practice could place residents at risk of a decline of their sense of dignity, level of satisfaction with life, and feelings of self-worth. Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included unspecified dementia , generalized muscle weakness, osteoarthritis (a type of generative joint disease), and senile degeneration of the brain (mental deterioration). Record review of Resident #1's quarterly MDS Assessment, dated 03/19/24, reflected a BIMS could not be conducted due to her rarely/never being understood. Section GG (Functional Abilities and Goals) reflected she was dependent for chair/bed-to-chair transfers. Record review of Resident #1's quarterly care plan, dated 02/01/24, reflected she was at low risk for falls related to deconditioning and paralysis with an intervention of following the facility fall protocol. There was no focus area related to ADLs or transferring status. Record review of Resident #1's physician order, dated 01/13/24, reflected using a hoyer lift for transfers every shift. (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 0550 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 06/13/24 at 11:15 AM, Resident #1's FM D stated they placed a surveillance monitor in her room and one of her biggest frustrations was staff did not announce who they were, did not explain what they were going to do, and often would just socialize with each other and not pay attention to the resident. FM D stated Resident #1 may not be able to communicate verbally, but she did understand when she was spoken to, and she knew she did not want to listen to the staff gossip. She stated there were many instances where Resident #1 was showing signs of fear when they were providing care due to the lack of knowledge as to what was happening . During an observation and interview on 06/13/24 at 11:31 AM revealed CNA A and CNA B getting ready to transfer Resident #1 with the use of a hoyer lift. Upon entering the room, they did not address Resident #1 or state their names or what they were going to do. CNA A attached the front loops of the sling to the lift while CNA B was behind her and attached the back loops to the lift. CNA B adjusted the sling by pulling it up which went over Resident #1's head and her eyes opened wide, opened her mouth and appeared panicked. CNA A stated, Going up and pushed the button to lift her from her wheelchair. Once she was maneuvered to the bed, they let the sling down onto the bed. They began to perform peri care by pulling down her pants and changing her brief. They rolled her from side to side without engaging with her. CNA A was talking to CNA B about how she had been working on another hall and CNA B was expressing how tired he was from working multiple shifts. Due to Resident #1's leg contractions, CNA B had to use slight force to open her knees so CNA A could perform peri care. Resident #1 at that point appeared to be fearful or in pain as her mouth opened and she grimaced. The State Surveyor then asked if either had been trained on explaining to the residents what they were going to do while providing care for residents. They both stated they had and CNA B stated he usually did but he was just tired and forgot. After State Surveyor intervention, they began letting Resident #1 know what was going on, for example, Okay we are going to pull your pants up now . During an interview on 06/13/24 at 3:19 PM, the DON stated her expectations when staff were providing care to residents, they speak to them like you and I are speaking to each other right now. She stated they needed to be professional and anything spoken about needed to be about nothing other than the resident and their care. She stated causing a resident to be scared or causing issues psychologically could be a negative outcome of staff not communicating to the resident . Record review of an in-service, dated 05/29/24, and conducted by the DON, reflected staff were educated on the following: Customer Service: Never have personal conversations with coworkers in front of residents or resident rooms. . AIDES - do this EVERY SINGLE TIME. Residents WILL FORGET YOU. They will get CONFUSED. Family members may mistake you for someone else as well. - Acknowledge - hello, How can I help you? - Introduce - My name is (name) and I am your aide today. - Duration - I just came to check on your water pitcher. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	- Explanation - and see if you need a refill. - Thank you - Ok you're all set. Thank you. Record review of the facility's Resident Rights Policy, revised February of 2021, reflected the following: Employees shall treat residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence b. be treated with respect, kindness, and dignity

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene for of five residents three (Resident #2, Resident #3 and Resident #4) of five residents reviewed for ADLs. The facility failed to provide showers to Residents #2, #3 and #4 in compliance with their shower schedules. This deficient practice could place residents at risk of a decline in hygiene, at risk of skin breakdown, level of satisfaction with life, and feelings of self-worth. Findings include: 1. Record review of Resident #2's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included unspecified intellectual disabilities, muscle weakness, lack of coordination, and difficulty in walking. Record review of Resident #2's quarterly MDS assessment, dated 05/20/24, reflected a BIMS of 14, which indicated he was cognitively intact. Section GG (Functional Abilities and Goals) reflected he required supervision or touching assistance with showering. Record review of Resident #2's quarterly care plan, dated 03/26/24, reflected he had an ADL self-care performance deficit related to fatigue with an intervention of needing minimal assistance with bathing. Record review of Resident #2's showering tasks in his EMR, from 05/13/24 - 06/13/24, reflected he received one shower on 06/04/24 . During an observation and interview on 06/13/24 at 10:04 AM revealed Resident #2 ambulating down the hallway. His hair was disheveled and his face had a good amount of scruff. He stated he rarely ever got a shower and his last one was sometime last week. He stated it made him feel bad and he often had to use the sink in his room to wash up . He stated he was supposed to be showered on Mondays, Wednesdays, and Fridays. 2. Record review of Resident #3's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident # 3 had diagnoses which included unspecified lack of coordination, major depressive disorder, hemiplegia (one-sided paralysis) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting right dominant side, and edema (swelling). Record review of Resident #3's quarterly MDS assessment, dated 05/22/24, reflected a BIMS of 10, which indicated a moderate cognitive impairment. Section GG (Functional Abilities and Goals) reflected she required supervision or touching assistance with showering. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's quarterly care plan, revised 03/06/24, reflected she had an ADL self-care performance deficit related to right hemiparesis, impaired balance, and pain with an intervention of being dependent on one staff to assist with showers. Record review of Resident #3's showering tasks in her EMR, from 05/13/24 - 06/13/24, reflected she received four showers - 05/30/24, 06/04/24, 06/11/24, and 06/13/24. During an observation and interview on 06/13/24 at 10:18 AM revealed Resident #3 ambulating out of her room. Her hair was disheveled. She stated it was impossible to get a shower and could not remember the last time she had one and it made her feel bad and gross . She stated he was supposed to be showered on Mondays, Wednesdays, and Fridays. 3. Record review of Resident #4's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included hemiplegia (one-sided paralysis) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting right dominant side, contractures , muscle weakness, and unspecified lack of coordination. Record review of Resident #4's quarterly MDS assessment, dated 05/20/24, reflected a BIMS of 15, which indicated he was cognitively intact. Section GG (Functional Abilities and Goals) reflected he required supervision or touching assistance with showering. Record review of Resident #4's quarterly care plan, dated 06/01/24, reflected he had limited physical mobility related to stroke and weakness with an intervention of providing supportive care. There was no focus or goals related to ADLs or showering. Record review of Resident #4's showering tasks in his EMR, from 05/13/24 - 06/13/24, reflected he received three showers - 05/29/24, 05/30/24, and 06/11/24. During an observation and interview on 06/13/24 at 10:24 AM revealed Resident #4 in his room. His clothes were covered in stains and his face was unshaven. He became extremely irate stating the staff never helped him with anything. He stated he did get a shower the previous Monday, 06/11/24, but he never received them regularly. He stated it made him feel dirty and left out. He stated he was living at the facility for a reason and he could not understand why he could not get more assistance with his care. He stated he was supposed to be showered on Mondays, Wednesdays, and Fridays. During an interview on 06/13/24 at 1:40 PM, CNA B stated they had shower aides who were responsible for giving resident showers. He stated if they did not show up to work, the other aides would give the showers. He stated sometimes they were not made aware the shower aides were not working so showers would sometimes go undone . During an interview on 06/13/24 at 3:10 PM, the DON stated they had two shower aides who assisted residents with showers. She stated, however, that any nurse or aide could give a shower. She stated it was the responsibly of the nurses to ensure showers were getting done regularly and as needed. She stated infection or hygiene issues could be a negative outcome of not receiving regular showers . Record review of an in-service, conducted on 05/07/24 by the DON, reflected staff were educated on the on their job descriptions: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care and Services: . bathes residents . Record review of the facility's Activities of Daily Living (ADL) Policy, revised March of 2018, reflected the following: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming and oral care)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview and record review the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of three residents (Resident #1) reviewed for mobility . The facility failed to apply a hand contracture cushion to Resident #1's contracted hand. This failure could place residents at risk for not receiving the appropriate care and services to maintain their highest practicable well-being. Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included unspecified dementia , generalized muscle weakness, and osteoarthritis (a type of generative joint disease). Record review of Resident #1's quarterly MDS Assessment, dated 03/19/24, reflected a BIMS could not be conducted due to her rarely/never being understood. Record review of Resident #1's quarterly care plan, dated 02/01/24, reflected she had chronic pain related to chronic physical disability to her left wrist/hand contracture with an intervention of anticipating her needs for pain relief. It further reflected she had an alteration in musculoskeletal related to left sided contracture to the hand, wrist, and elbow with an intervention of educating resident/family/caregivers on joint conservation techniques. She had an actual impairment to skin integrity of the left hand related to wound from nail/thumb with an intervention of following facility protocols for treatment of injury. Record review of Resident #1's physicians order, dated 05/17/24, reflected to monitor left hand/index finger for skin breakdown. Remove hand contracture cushion and clean with soap and water. Pat dry and apply cushion to hand every day shift every Monday, Wednesday, and Friday. During an observation and interview on 06/13/24 at 11:31 AM revealed CNA A and CNA B getting ready to transfer Resident #1 to her bed by utilizing a hoyer lift. Resident #1's left hand was contracted and there was not a cushion in her hand. CNA A asked where the cushion was and CNA B stated there should be one in her hand and the nurses were the ones who placed them there. CNA B went to Resident #1's bedside drawers and pulled out a small cushion for her hand . During an interview on 06/13/24 at 11:58 AM, LVN C stated the nurses were responsible for ensuring Resident #1's hand cushion was inserted daily to support her hand contracture. She stated she removed it the day prior, 06/12/24, to cleanse the wounds on her hands and must have forgotten to place it back . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/24 at 3:19 PM, the DON stated it was the nurse's responsibility to ensure Resident #1 had her contracture cushion in place in her left hand. She stated it was important to follow physician orders in order to prevent her hand from contracting further or causing irritation or wounds to her palm. Record review of the facility's Physician Orders Policy, revised February of 2021, reflected it did not address the importance of following physician orders .