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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455889 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/19/2024 |
| NAME OF PROVIDER OR SUPPLIER Lily Springs Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (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** 39269</p> <p>Based on interviews and record reviews the facility failed to implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs for one resident (Resident #1) of three (3) residents reviewed for care plans.</p> <p>The facility failed to ensure Resident #1's care plan was completed upon admission and revised or updated to reflect changes in Resident #1's care needs for falls, medications (antibiotics, anti-hypertensive, anti-depressant), Cognition.</p> <p>This failure placed residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in a decline in physical and psychosocial well-being.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet date 07/19/2024 reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Recurrent Major Depressive Disorder (mental health disorder having episodes of psychological depression, Age-related Cognitive Decline, Difficulty in walking, Pain in Unspecified Joints, Insomnia (trouble falling or staying asleep), Urinary Tract Infection, Essential (Primary) Hypertension (high blood pressure that is not caused by a medical condition).</p> <p>Review of Resident #1's care plan initiated 03/16/2024 and revised 03/18/2024 only addressed Resident #1's as wandering risk related to confusion and wandering behavior. There was no other care plan completed for Resident #1 to include other health concerns such as infection upon admission, depression, hypertensions, cognitive impairment, multiple falls.</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.

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| 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>Review of Resident #1's comprehensive MDS assessment dated [DATE] reflected a BIMS score of 06 indicating severe cognitive impairment. Section D-Mood reflected Resident #1 was feeling down, depressed, or hopeless for 12-14 days (nearly every day). Section I- Active Diagnosis included Hypertension, Urinary Tract Infection, Depression, Insomnia, Acute Cystitis without Hematuria (infection in the bladder without blood in the urine), Encephalopathy (a medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion), pain in unspecified joint. Section N- Medications reflected Resident #1 took Antibiotics for infection and antidepressant medication.</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 04 indicating severe cognitive impairment. Section D-Mood reflected Resident #1 was feeling down, depressed, or hopeless 2-6 days (several days). Section I- Active Diagnosis included Hypertension, Recurrent Major Depressive Disorder, Insomnia, Acute Cystitis without Hematuria, Encephalopathy, pain in unspecified joint. Section N- Medications reflected Resident #1 was took an antidepressant medication.</p> <p>Review of Resident #1's clinical assessments from 03/09/2024 through 07/19/2024 reflected the following:</p> <p>PHQ-9 assessment dated [DATE] score of 7.0 indicating Mild Depression. (PHQ-9 is a multiple-choice self-report inventory that is used as a screening and diagnostic tool for mental health disorders of depression, anxiety, alcohol, eating and somatoform disorders)</p> <p>Fall risk assessment dated [DATE] with score of 60.0 indicating high risk for falling.</p> <p>Morse Fall Scale-Post fall assessment dated [DATE] with a score of 95.0 indicating high risk for falling.</p> <p>Morse Fall Scale-Post fall assessment dated [DATE] with a score of 55.0 indicating high risk for falling.</p> <p>PHQ-9 assessment dated [DATE] score of 1.0 indicating Minimal Depression</p> <p>BIMS assessment dated [DATE] with score of 08 indicating moderate cognitive impairment.</p> <p>PHQ-9 assessment dated [DATE] score of 3.0 indicating Minimal Depression</p> <p>BIMS assessment dated [DATE] with score of 04 indicating severe cognitive impairment.</p> <p>Review of facility's incident reports from 04/2024 through 07/19/2024 reflected Resident #1 fell on the following dates: 05/21/2024 and 06/04/2024.</p> <p>Review of Resident #1's progress notes dated 03/12/2024 reflected Resident #1 took antibiotics for UTI.</p> <p>Review of Resident #1's progress notes dated 05/21/2024 reflected Resident #1 had a fall while going to the restroom.</p> <p>(continued on next page)</p> | | |

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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>Review of Resident #1's progress notes dated 06/04/2024 reflected Resident #1 had a fall from his wheelchair to the floor.</p> <p>Resident #1's physician orders reflected the following orders:</p> <p>Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for Pain related to PAIN IN UNSPECIFIED JOINT, not to exceed 300 mg per 24 hours dated 03/09/2024.</p> <p>Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED dated 03/09/2024.</p> <p>Melatonin Oral Tablet 5 MG (Melatonin) Give 1 tablet by mouth every 24 hours as needed for Insomnia related to INSOMNIA, UNSPECIFIED dated 03/09/2024.</p> <p>Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold Bp medication for systolic less than 100 and diastolic less than 40. Hold for pulse less than 60, dated 05/03/2024.</p> <p>hydrALAZINE HCl Oral Tablet 100 MG (Hydralazine HCl) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold Bp medication for systolic less than 100 and diastolic less than 40, dated 5/03/2024.</p> <p>NIFEdipine ER Tablet Extended Release 24 Hour 90 MG Give 1 tablet by mouth one time a day for hypertension related to ESSENTIAL (PRIMARY) HYPERTENSION Hold Bp medication for systolic less than 100 and diastolic less than 40, dated 05/03/2024.</p> <p>During an interview on 07/19/2024 at 1:34 pm, the DON stated Resident #1's initial care plan was not completed because it only addressed the Resident's need for secure unit. The DON stated care plan were supposed to be completed within 48 hours upon admission, quarterly and updated as needed for change of condition. The DON stated the MDS Nurse was responsible to complete care plans and updates as needed.</p> <p>During an interview on 07/19/2024 at 2:35 pm the MDS Nurse stated he had worked at the facility since March of 2024. The MDS Nurse also stated he was still trying to figure out his job duties. The MDS Nurse stated he was responsible to complete care plans and updates as needed upon admission, quarterly and as needed. The MDS Nurse stated he had trouble with Point click Care documenting system and he was under the impression that he did not have to do care plans much. The MDS Nurse stated he was trained on how to do care plan upon hired but he needed more instructions. The MDS Nurse stated it was assumed by management that he knew how to complete a care plan in point click care because he had previously worked as an MDS Nurse. The MDS Nurse stated Resident 1#'s initial care plan was not completed, there were no other care plans completed for Resident #1 since his admission to the facility in March of 2024. The MDS Nurse stated he should have completed care plans for Resident #1 every time an MDS assessment was completed.</p> <p>(continued on next page)</p> | | |

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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>During another interview on 07/19/2024 at 3:10 pm the DON stated she was responsible to ensure the MDS Nurse was completing care plans as needed. The DON stated she had not been checking to ensure care plan plans were being completed because she had been busy. The DON stated the MDS Nurse was orientated to Point Click Care, and she had personally shown the MDS Nurse on completing care plans. The DON stated she assumed the MDS Nurse knew how to complete care plan in Point Click Care because he was a seasoned MDS Nurse.</p> <p>Review of the MDS nurse's training records reflected the MDS nurse completed the following training on 03/14/2024 in point click care: Assessments, Care Plan Reviews, Care Plan for Skilled Nursing facilities, Documents, MDS 3.0 Care Area Assessments, MDS 3.0 Data Entry, MDS 3.0 monitoring and Managing, MDS 3.0 Submission.</p> <p>Review of the MDS nurse personnel file reflected effective date of hired was 03/11/2024 and was signed by the MDS nurse on 02/26/2024.</p> <p>Review of facility's document titled position description for MDS Coordinator updated 04/2017 reflected:</p> <p>Assist the Resident Care Coordinator to fulfill responsibilities, as directed.</p> <p>Conduct orientation sessions on the MDS process to all associates involved.</p> <p>Maintains documentation of all orientation/training sessions.</p> <p>Serve as a resource person for the Resident Care Planning activities.</p> <p>Complete MMQ and turnaround documents in a timely manner and communicate as needed with appropriate state departments.</p> <p>Ensures that the quality and appropriateness of the resident care meets or exceeds company and industry standards and ensures that all nursing services are in compliance with state and federal legal, regulatory, accreditation and reimbursement guidelines.</p> <p>Review of facility's document titled Nexion Code of Conduct revised 10/2022 reflected:</p> <p>Resident Assessment--To ensure that our residents are cared for in a manner that safeguards their welfare while assuring that each resident maintains the highest level of autonomy, self-esteem, and quality of life, each resident will receive comprehensive assessments. The assessments will identify each resident's medical needs, factors that are unique to the resident and may have the potential for causing harm to the resident or decreasing the resident's autonomy or quality of life. Included in Nexion's comprehensive assessment process are tools to determine residents' risk of falling or wandering away from the facility, nutritional needs and requirements, incontinence problems, and the need for behavior management or physical or chemical restraints. Based upon the results of the assessments, each resident's individual needs will be incorporated into a care plan that will be periodically reevaluated. Each resident's plan of care will be modified as necessary to provide an appropriate balance of quality medical care, protection from harm, and independence.</p> <p>(continued on next page)</p> |

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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>Review of facility's document titled Care Plans, Comprehensive Person-Centered revised January 2023 reflected:</p> <p>Policy Statement</p> <p>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> <p>Policy Interpretation and Implementation</p> <p>--The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.</p> <p>--The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p>--The comprehensive, person-centered care plan will---Include measurable objectives and timeframes, Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such as desire. Incorporate identified problem areas; incorporate risk factors associated with identified problems; Reflect the resident's expressed wishes regarding care and treatment goals; Reflect treatment goals, timetables and objectives in measurable outcomes.</p> <p>-- The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).</p> <p>-- Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p> | | |