

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 08/21/2024
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.

(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 interviews and record reviews, the facility failed to develop the comprehensive person-centered care plan for one resident (Resident #1) out of five residents reviewed for the development of the comprehensive care plans.</p> <p>The facility failed to ensure Resident #1 had a comprehensive person-centered care plan.</p> <p>This deficient practice places the resident at risk for not receiving the necessary and appropriate care.</p> <p>Findings included:</p> <p>A record review on 08/21/2024 of Resident #1's face sheet dated 06/12/2024 reflected admission to the facility on [DATE]. She is a [AGE] year-old male. The residents' diagnoses included: Alzheimer's disease (an irreversible brain disease that destroys memory, thinking and the ability to carry out daily activities), polyarthritis (refers to a joint disease that involves at least 5 joints, inflammation, pain, movement restriction, warmth, swelling and redness can occur) and dementia (a group of conditions characterized by impairment of at least two brain functions such as memory loss and judgment).</p> <p>A record review of Resident #1's initial MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated Resident #1's cognition was severely impaired. She was dependent on staff for supervision and touching assistance for her ADLs. Toileting was not addressed on this MDS assessment.</p> <p>A record review of the Residents #1's care plan in PCC reflected no comprehensive care plan. There was a baseline care plan completed on 06/8/2024.</p> <p>In an interview on 08/21/2024 at 04:30 PM with the LVN, she stated there should have been a baseline and comprehensive care plan for every resident. She stated that without a care plan the staff would have had nothing to follow regarding the resident's ambulation, eating, walking, and ADLs.</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>In an interview on 08/21/2024 at 04:50 PM with the DON, she stated the MDS Nurse was responsible for completing the care plans, but the position was vacated two weeks ago. She stated the expectation was for all residents to have a baseline care plan completed within 48 hours and a comprehensive care plan completed within 21 days. She identified potential adverse outcomes for the resident were that staff would have had no direction to provide care to the residents.</p> <p>In an interview on 08/21/2024 at 05:30 PM with the ADM, she stated the MDS Nurse was responsible for completing the care plans, but the position was vacated two weeks ago. She stated the expectation was for all residents to have a baseline and comprehensive care plan documented in PCC. She stated the care plan was the instruction on how to provide care for the residents, and without a care plan, one would not know how the residents needed to be fed, how to transfer them, their code status, and their personal preferences. She stated, without a care plan, staff could not provide care very well or to the extent the resident needed. She stated, There is more to caring for a resident than just physicians' orders.</p> <p>A record review on 08/21/2024 of the facility's policy, titled Care Plan - Baseline, Revised March 2022, reflected in part:</p> <p>Policy Interpretation and Implementation</p> <p>2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50360</p> <p>Based on observation and interview, the facility failed to ensure all drugs and biological's were in locked compartments and inaccessible to unauthorized staff, visitors, and residents for one (Med Cart #1) of six medication carts reviewed for medication storage in that:</p> <p>The MA failed to lock and secure Med Cart #1.</p> <p>This failure could allow residents, visitors and unauthorized staff access to prescription and over-the-counter medications.</p> <p>Findings Included:</p> <p>Observation on 08/21/2024 at 9:04 am revealed, Med Cart #1, sitting in the hallway near nurses' station, was unsupervised and unlocked. Review of the cart's contents revealed prescription and over-the counter medications and ointments, glucometer supplies, insulin pens, and insulin syringes. The MA assigned to the cart was not within eyesight. Another staff member shouted the MA's name down the hall and quickly locked the cart. There were numerous staff and residents in the hallway around the nurse's station.</p> <p>In an interview on 8/21/2024 at 4:00 PM with the MA, she stated she had worked at the facility for ten years and the most recent in-service on med-cart safety was within the last two weeks and it was conducted by the DON. She stated the medication cart and computer should have been locked when she stepped away from the cart. She identified resident risks as a resident could have taken medication that was not prescribed and they could have an allergic reaction.</p> <p>In an interview on 08/21/2024 at 04:30 PM with the LVN, she stated, [the medication carts] should have been locked as soon as you are done. She identified resident risks as, They could take medication to which they are allergic. We could kill them. She stated her expectation was for the medication cart to have been locked, unless standing right in front of it.</p> <p>In an interview on 08/21/2024 at 04:50 PM with the DON, she stated her expectation was that medication carts were locked before staff walked away. She identified resident risks as allergic reactions to medications and overdose.</p> <p>In an interview on 08/21/2024 at 05:30 PM with the ADM, she stated her expectation was that anytime staff moved away from the cart, it should have been locked. She identified resident risks as they could have gotten ahold of medications they are not supposed to have, items could have become lost, and medications could have been stolen and/or misused.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50360</p> <p>Based on interviews and record reviews, the facility failed to develop the comprehensive person-centered care plan for one resident (Resident #1) out of five residents reviewed for the development of the comprehensive care plans.</p> <p>The facility failed to ensure Resident #1 had a comprehensive person-centered care plan.</p> <p>This deficient practice places the resident at risk for not receiving the necessary and appropriate care.</p> <p>Findings included:</p> <p>A record review on 08/21/2024 of Resident #1's face sheet dated 06/12/2024 reflected admission to the facility on [DATE]. She is a [AGE] year-old male. The residents' diagnoses included: Alzheimer's disease (an irreversible brain disease that destroys memory, thinking and the ability to carry out daily activities), polyarthritis (refers to a joint disease that involves at least 5 joints, inflammation, pain, movement restriction, warmth, swelling and redness can occur) and dementia (a group of conditions characterized by impairment of at least two brain functions such as memory loss and judgment).</p> <p>A record review of Resident #1's initial MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated Resident #1's cognition was severely impaired. She was dependent on staff for supervision and touching assistance for her ADLs. Toileting was not addressed on this MDS assessment.</p> <p>A record review of the Residents #1's care plan in PCC reflected no comprehensive care plan. There was a baseline care plan completed on 06/8/2024.</p> <p>In an interview on 08/21/2024 at 04:30 PM with the LVN, she stated there should have been a baseline and comprehensive care plan for every resident. She stated that without a care plan the staff would have had nothing to follow regarding the resident's ambulation, eating, walking, and ADLs.</p> <p>In an interview on 08/21/2024 at 04:50 PM with the DON, she stated the MDS Nurse was responsible for completing the care plans, but the position was vacated two weeks ago. She stated the expectation was for all residents to have a baseline care plan completed within 48 hours and a comprehensive care plan completed within 21 days. She identified potential adverse outcomes for the resident were that staff would have had no direction to provide care to the residents.</p> <p>(continued on next page)</p>

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