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	10/08/2024

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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to implement an admissions policy that did not request or require residents to waive potential facility liability for loss of personal property for three (Resident #1, Resident #2, and Resident #3) of five residents reviewed for inventory of personal property. The facility to have a completed inventory of personal property lists for Residents #1, #2, and #3. This failure could place residents at risk of not having personal property replaced in the event of damage or loss. Findings included: Review of the facility's undated admission packet reflected the following: 21. PERSONAL BELONGINGS. Resident/Resident Representative shall complete and sign Facility's written inventory form listing Resident's personal belongings at the time of admission. An original inventory shall be retained by Resident/Resident Representative as a receipt and a copy will be kept with the Resident's records . Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (stroke), type II diabetes, generalized anxiety disorder, and major depressive disorder. Review of a grievance filed by Resident #1's FM A , dated 10/07/24, reflected the following: [FM A] reported to Admin that [Resident #1]'s tablet with cover and watch were missing . Resident #1 was reimbursed by the facility. Review of Resident #1's admission packet, in his EMR, on 10/08/24, reflected there was no completed inventory sheet. Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including bipolar disorder, major depressive disorder, personal history of TBI, and dementia. (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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's quarterly care plan, dated 08/29/24, reflected a BIMS of 12, indicating a moderate cognitive impairment. Review of Resident #2's admission packet in his EMR, on 10/08/24, reflected there was no completed inventory sheet. Review of Resident #3's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic kidney disease, bipolar disorder, and difficulty in walking. Review of Resident #3's quarterly MDS, dated [DATE], reflected a BIMS of 7, indicating a severe cognitive impairment. Review of a self-report admitted to HHSC by the ADM, dated 08/20/24, reflected Resident #3 alleged his property is missing. Review of Resident #3's admission packet in his EMR, on 10/08/24, reflected there was no completed inventory sheet. Yes and During an interview on 10/08/24 at 10:32 AM, Resident #3 stated he had a locked box when he arrived with a cell phone, custom-made silver ring, and a couple of silver necklaces. He stated a few weeks later when he looked in the box, all his belongings were gone. He stated he told management about it but had never gotten his belongings back. During an interview on 10/08/24 at 12:56 PM, the SW stated Resident #3 alleged many times that he was admitted with all these belongings that he actually did not come in with. She stated he was very confused and talked often about his missing jewelry and a cell phone. She stated the facility never presented him with a locked box. The SW was asked if he had an inventory sheet and she stated as far as she knew, they did not complete inventory sheets upon admission. She stated she had recently brought it up to management that it should be done. She stated they were important so they could keep track of what personal belongings the residents had in case they were to go missing. A request was made for a policy on admissions/inventory sheets but was not received prior to exiting. During an interview on 10/08/24 at 2:32 PM, LVN A stated she assumed the admitting nurses or resident family members completed the inventory sheets upon admission. She stated she was new to the facility and had not yet admitted a new resident. She stated she had not seen any inventory sheets for residents. She stated it was important they were completed so the facility could keep track of what the residents owned. She stated the facility was the residents' home and they deserved to have their own personal belongings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47065 Based on observations, interviews, and record reviews, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for one of one medication room reviewed for pharmacy services. The facility failed to ensure the medication room was kept locked or under direct supervision of authorized staff on 10/08/24. This failure could place residents at risk of having unauthorized staff having access to their medications, and accessing and ingesting medications that could cause clinically significant adverse consequences necessitating hospitalization to stabilize residents,. Findings included: An observation of the medication room on 10/08/24 at 11:10 a.m. revealed the medication room door was unlocked. There was no staff directly supervising the unlocked medication room. Residents were rolling their wheelchairs passed the unlocked medication room. During an interview on 10/08/24 at 11:12 a.m., when asked why the medication room was unlocked, the ADON stated there was a nursing staff member who walked out of the medication room to grab something and was coming back to the room. The ADON did not indicate who the staff member was. ADON stated the medication room was usually locked when not in use. The ADON stated authorized staff, such as nurses, medication aides and herself, had access to the medication room. If the medication room was left unlocked and not supervised by authorized staff, residents could be at risk of having their medications taken. An observation on 10/08/24 at 11:26 a.m. revealed the ADON walked out of the medication room. The ADON did not lock the medication room when she left. During an interview on 10/08/24 at 1:31 p.m., RN A stated nurses and medication aides had access to the medication room. RN A stated the medication room should be locked at all times. RN A stated residents' health and safety could be at risk if the medication room was left unlocked because PRN, insulin, and over the counter medications were stored in the medication room and confused residents could ingest them and residents could also miss medication doses. During an interview on 10/08/24 at 1:49 p.m., LVN B stated the DON, the ADON, nurses, and medication aides had access to the medication room. LVN B stated the medication room was supposed to be locked at all times. LVN B stated staff have to be aware that door was locked at all times. LVN B stated if the medication room was left unlocked, medications could potentially go missing. Review of the facility's medication labeling and storage policy, revised February 2023, reflected: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.