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	03/03/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, including to the state Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities, in accordance with State law through established procedures for one of seven residents (Resident #1) reviewed for abuse and neglect . The facility failed to report to the State Survey Agency an incident when Resident #1's Advanced Directive was not followed, and CPR was not administered to Resident # 1. Resident #1 expired on [DATE] at the facility. This failure could place residents at risk of abuse or and neglect. Findings include: Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included heart failure (heart does not pump as well as it should), diabetes (body have trouble controlling blood sugar energy) and hypertension (high blood pressure). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated intact cognition. Resident #1 could make himself understood and was able to understand verbal content. Record review of TULIP did not reflect a facility self-report was made to the state survey agency when the incident occurred with Resident #1 on [DATE] when code status was not honored, and he expired. (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

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 03/03/2025
NAME OF PROVIDER OR SUPPLIER Lily Springs Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Central Texas Expwy Lampasas, TX 76550	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes, dated [DATE] at 8:00 PM, written by RN A, reflected [Resident #1] presented to nurse with chest pain and shortness of breath, swearing, anxious. Saturations 84% on room air. Oxygen 2 liters applied. Blood pressure ,d+[DATE], heart rate 88. One sl not given. Rated pain ,d+[DATE]. 8:10 B/P ,d+[DATE], hr 89. 2nd sl not given. 8:15 B/P ,d+[DATE], hr 76. Aspirin 81 mg po given, EMS, DON, Family. EMS arrived at 8:23 PM. Record review of Resident #1's progress notes, dated [DATE] at 8:30 PM, written by RN A, reflected EMS placed resident on monitor. Talking to resident, all of a sudden resident fell back in bed and became non-responsive. Monitor showed PEA (without pulse). Patient was pronounced at 8:36 PM. No pulse, no respirations, no signs of life. Family arrival pending. Funeral home notified . During an interview with the DON on [DATE] at 6:22 PM, she stated she started with the facility on [DATE]. The DON stated she was not at the facility when Resident #1 expired. It was expected to make state reportable with it was determined Resident #1's code status was not honored. The ADM would have been responsible for reporting the incident to the state agency immediately after the incident on [DATE]. During an interview with the ADM on [DATE] at 6:48 PM, she stated she would have been the one to make the self-report when it was determined Resident #1's code status was not granted. The ADM stated she knew it was expected to make the report and the state reportable was not sent in . The ADM stated not sending in a state reportable would cause further neglect with residents. The ADM would not elaborate any further on the state reportable and she broke down crying and left the room. Record review of the facility's policy, dated [DATE], reviewed [DATE], titled Abuse Prohibition Policy revealed The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation. Record review of HHSC's PL ,d+[DATE], dated [DATE], reflected emergency situations that pose a threat to resident health and safety should be reported to HHSC immediately, but not later than 24 hours after the incident occurs or is suspected.

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives and timeframes that met a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 7 residents (Resident #1) reviewed for care plans. The facility failed to develop a care plan which reflected Resident #1's Advanced Directive was full. Resident # 1 expired at the facility on [DATE] and there was no CPR performed . An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE] at 3:11 pm, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems . This failure could place residents at risk of injury, harm, impairment or death to a resident receiving care in this facility. Findings include: Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included heart failure (heart does not pump as well as it should), diabetes (body have trouble controlling blood sugar energy) and hypertension (high blood pressure). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated intact cognition. Resident #1 could make himself understood and was able to understand verbal content. Record review of Resident #1's care plan, dated [DATE], did not reflect an Advance Directive. Record review of Resident #1's care plan meeting notes, dated [DATE], signed by the SW reflected under the Advanced Directive section: Want to change to full code, currently DNR. Record review of Resident #1's progress notes, dated [DATE] at 10:20 AM, written by the SW, reflected SW met with [Resident #1] at bedside to conduct MDS assessment. [Resident #1] appears to be alert and oriented, [Resident #1] hearing is minimal difficulty, but vision is adequate with glasses, impaired without them. [Resident #1] has clear speech and able to voice his needs/wants. [Resident #1] stated that he had been doing okay but he was having a hard time breathing, gaining weight so he may be overeating and feeling depressed because of his heart. [Resident #1] discharge plan is to remain at the facility LTC. [Resident #1] is his own RP. [Resident #1] wishes to change from DNR to full code. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress notes, dated [DATE] at 10:32 AM, written by the SW, reflected SW met with [Resident #1] at bedside to conduct MDS assessment. [Resident #1] appears to be alert and oriented. [Resident #1] hearing is minimal difficulty, but vision is adequate with glasses, impaired without them. [Resident #1] has clear speech and able to voice his need/wants. [Resident #1] stated that he has been doing okay but still gets depressed because of his health condition. [Resident #1] discharge plan is to remain at the facility LTC. [Resident #1] is his own RP. [Resident # 1] wishes to remain full code. During an interview with the SW on [DATE] at 4:05 PM, the SW stated the MDS Coordinator would have been responsible for making sure Resident #1's code status was updated in the care plan. The SW stated that it was expected for the care plan to be reflected with Resident #1's code status so his wishes would have been followed. During an interview with the MDS Coordinator on [DATE] at 10:25 PM, stated she was not working as MDS Coordinator when Resident #1 changed his code status from DNR to full code at the care plan meeting [DATE]. The Prev MDS Coordinator would have been responsible for making sure Resident #1's code status was updated. The MDS Coordinator stated the MDS Coordinators were responsible for making sure the care plans were updated. The MDS Coordinator stated it was expected for Resident #1's code status to be included on the care plan. The MDS Coordinator stated without the care plan being updated there was no way to know what care to provide and the care would not have been provided . During an interview with the DON on [DATE] at 6:22 PM, she stated she was not working at the facility when Resident #1 changed his code status on [DATE]. The DON stated there was a Prev MDS Coordinator who was no longer at the facility who would have been responsible for developing Resident #1's care plan to show an Advanced Directive of Full Code. The DON stated it was expected for Resident #1's Advanced Directive to be developed in the care plan. Resident #1's wishes were not followed, and his rights were not followed. During an interview with the ADM on [DATE] at 6:48 PM, the ADM stated it was the Prev MDS Coordinator who would have been responsible for implementing and changing the code status on the care plan for Resident #1. The ADM stated it was expected for the code status to be documented in Resident #1's care plan. The ADM stated the Prev DON would have been responsible for making sure the care plans were correct. The ADM stated without the code status being documented in the care plan Resident #1 was not provided CPR and his wishes were not followed. Interview attempted with the Prev MDS Coordinator on [DATE] at 1:28 PM was unsuccessful. Left voice message for the Prev MDS Coordinator to return call. The Prev MDS never returned call . Interview attempted with the Prev DON on [DATE] at 1:30 PM was unsuccessful. Left voice message for the Prev DON to return call. The Prev DON never returned call. Record review of the facility's policy, dated [DATE], reviewed [DATE], titled Care Plans, Comprehensive Person -Centered reflected, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 7:42 PM. The ADM was notified. The ADM was provided with the IJ template on [DATE] at 7:42 PM . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following Plan of Removal submitted by the facility was accepted on [DATE] at 7:25 am: [DATE] F657 - The facility failed to ensure Resident #1 code status was care planned. The following actions were immediately put into place: A comprehensive review of all residents was conducted to verify code status and to ensure care plan status reflects resident current choices by DON, ADON, and Corporate Clinical Specialists on [DATE] . An Ad Hoc QAPI was held on [DATE], to include Medical Director, DON, Administrator and Corporate Clinical Specialist. A care plan training session was successfully conducted by Corporate Clinical Specialist with the interdisciplinary team, focusing on the detailed process of updating code status within the care plan, as well as providing clear instructions on how to effectively implement and modify any necessary changes. During the training, the participants demonstrated their ability to competently identify the Interdisciplinary Team (IDT), showcasing their understanding of the collaborative roles involved on [DATE]. DON/Designee will be responsible for oversight of the IDT process for updating code status within care plan . The above information will be included in new hire orientation, by the Administrator effective [DATE]. Monitoring and Audits: The DON/designee will ensure advance directive care plans are updated immediately following a status change and will conduct audits of advance directive care plans to ensure accuracy in electronic medical records (E.M.R.) weekly x 4 weeks. After 4 weeks, the DON/designee will follow the above process twice a month for 8 weeks, then monthly thereafter. The facility QA Committee will meet weekly starting [DATE], for the next eight weeks to review compliance with the plan of action. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. Monitoring of the POR included the following: Record review of the comprehensive audit of all residents to verify care plan reflected residents current Advanced Directive choice was completed on [DATE] . Record review of care plan training in service with facility nursing staff was completed on [DATE] . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the ADON on [DATE] at 12:30 PM, she stated she was trained on [DATE] with the CCS on care plans. The ADON stated care plans would need to be updated by any nurse. The ADON stated no one person was responsible for updating the care plans. The ADON stated the DON would be responsible for making sure the care plans were correct. During an interview with RN B on [DATE] at 12:57 PM, she stated she received her training on [DATE] with the ADON on care plans. RN B stated changes to care plans would need to be made immediately. RN B stated the DON would be responsible for checking the care plans for accuracy. During an interview with RN C on [DATE] at 1:03 PM, she stated she was trained on [DATE] with the ADON over care plans. RN C stated she trained on making sure care plans were updated immediately when there was a change or change in condition. RN C stated any nurse could update the care plan and the DON would be responsible to make sure the care plans were correct. During an interview with LVN D on [DATE] at 1:20 PM, she stated she was trained on [DATE] on care plans with the DON. LVN D stated care plans could be updated by any nurse and would need to be updated immediately. LVN D stated when a code status changed it would need to be updated immediately. During an interview with LVN E on [DATE] at 1:29 PM, stated the CCS trained her on [DATE] over care plans. LVN E stated care plans were updated immediately, and any nurse could update. LVN E stated the care plans would be checked by the DON. During an interview with the DON on [DATE] at 2:30 PM, she stated she received her care plan training on care plans on [DATE] with the CCS. The DON stated there was not one person responsible for updating care plans and all nursing staff could update or implement. The DON stated care plans would be updated immediately at the change or change in condition. The DON would be checking for accuracy on care plans and it also could be delegated to a nurse. The DON stated all nursing staff completed their care plan training on [DATE] and any new hires would receive their care plan training at new hire orientation. During an interview with the ADM on [DATE] at 2:45 PM, stated she completed her in service on [DATE] with the CCS over care plans. The ADM stated all nursing staff were trained on care plans as of [DATE]. The ADM stated all nursing staff were able up implement and update care plans. The ADM stated the DON or designee would be responsible for making sure the care plans were correct. The ADM was informed the Immediate Jeopardy was removed on [DATE] at 3:11 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review the facility failed to provide basic life support, including CPR, to a resident requiring emergency care prior to the arrival of emergency medical personnel and related physician orders and the residents advance directives for one of seven (Resident #1) residents reviewed for CPR . The facility failed to update Resident #1's records to reflect he requested a change in his code status on [DATE] from DNR (do not resuscitate) to Full Code. As a result, basic life support measures, which included CPR (Cardiopulmonary Resuscitation) were not provided to Resident #1 when Resident #1 fell back in his bed while talking to Emergency Medical Services and expired on [DATE]. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE] at 3:11 pm, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of injury, harm, impairment or death. Findings include: Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included heart failure (heart does not pump as well as it should), diabetes (body have trouble controlling blood sugar energy), and hypertension (high blood pressure). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated intact cognition. Resident #1 could make himself understood and was able to understand verbal content. Record review of Resident #1's care plan, dated [DATE], did not reflect an Advance Directive. Record review of Resident #1's care plan meeting notes, dated [DATE] , signed by SW reflected under the Advanced Directive section: Want to change to full code, currently DNR. Record review of Resident #1's progress notes, dated [DATE] at 10:20 AM, written by the SW, reflected SW met with [Resident #1] at bedside to conduct MDS assessment. Resident #1 appears to be alert and oriented, [Resident #1] hearing is minimal difficulty, but vision is adequate with glasses, impaired without them. [Resident #1] has clear speech and able to voice his needs/wants. [Resident #1] stated that he had been doing okay but he was having a hard time breathing, gaining weight so he may be overeating and feeling depressed because of his heart. [Resident #1] discharge plan is to remain at the facility LTC. [Resident #1] is his own RP. Resident #1 wishes to change from DNR to full code. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress notes, dated [DATE] at 10:32 AM, written by the SW, reflected SW met with [Resident #1] at bedside to conduct MDS assessment. [Resident #1] appears to be alert and oriented. [Resident #1] hearing is minimal difficulty, but vision is adequate with glasses, impaired without them. [Resident #1] has clear speech and able to voice his need/wants. [Resident #1] stated that he has been doing okay but still gets depressed because of his health condition. [Resident #1] discharge plan is to remain at the facility LTC. [Resident #1] is his own RP. [Resident # 1] wishes to remain full code. Record review of Resident #1's progress notes, dated [DATE] at 8:00 PM, written by RN A, reflected [Resident #1] presented to nurse with chest pain and shortness of breath, swearing, anxious. Saturations 84% on room air. Oxygen 2 liters applied. Blood pressure ,d+[DATE], heart rate 88. One sl not given. Rated pain ,d+[DATE]. 8:10 B/P ,d+[DATE], hr 89. 2nd sl not given. 8:15 B/P ,d+[DATE], hr 76. Aspirin 81 mg po given, EMS, DON, Family. EMS arrived at 8:23 pm. Record review of Resident #1's progress notes, dated [DATE] at 8:30 PM, written by RN A, reflected EMS placed resident on monitor. Talking to resident, all of a sudden resident fell back in bed and became non-responsive. Monitor showed PEA(without pulse). Patient was pronounced at 8:36 PM. No pulse, no respirations, no signs of life. Family arrival pending. Funeral home notified. Record review of Resident #1's DNR form, dated [DATE], reflected a form signed by Resident #1 and two witnesses. During an interview with the SW on [DATE] at 4:05 PM, the SW stated Resident #1 requested at the care plan meeting on [DATE] that Resident #1 requested his code status of DNR to full code. The SW stated the MDS Coordinator was responsible for updating the care plan from DNR to full code. The SW stated after the care plan meeting on [DATE], she removed the DNR from the binder at the nurse's station. The SW stated she met with Resident #1 on [DATE] to conduct his Quarterly MDS and Resident #1 had expressed he wanted to remain full code . During an interview with the MDS Coordinator on [DATE] at 10:25 AM, she stated she started in [DATE] date not recalled as the MDS Coordinator. The MDS Coordinator stated she was not the MDS coordinator when Resident #1 requested his code status be changed from DNR to full code. The MDS Coordinator stated the MDS Coordinator would be responsible for updating the code status to reflect the change of the DNR to full code . During an interview with the NP on [DATE] at 1:00 PM, the NP stated she was not told about Resident #1's code status was an error until after he expired on [DATE]. The NP stated her records reflected Resident #1's code status was DNR. The NP stated it was expected for the directive to have been updated and Resident #1's code status be followed per his wishes. The NP stated with no attempt to provide life saving measures Resident #1's wishes were not followed. During an interview with RN A on [DATE] at 1:29 PM, RN A stated Resident #1 came out of his room to the nurse's station on [DATE] around 8:00 PM and she immediately noticed Resident #1 was in distress. RN A stated Resident #1 was sweating and she started assessing Resident #1 's blood pressure and it was elevated. RN A stated she gave Resident #1 oxygen, a nitro, and called 911. RN A stated when EMS arrived and talked to Resident #1, he fell back in the bed and became nonresponsive. RN A checked in PCC, and it had DNR for Resident #1 and that was followed. RN A stated no CPR was performed because the code status in PCC showed DNR . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with RN B on [DATE] at 2:19 PM, she stated she was finishing up on notes in the evening time not recalled on [DATE] when Resident #1 walked up to the nurse's station to state he did not feel well. RN B stated RN A assessed Resident #1 and called 911. RN B stated the last thing she knew, Resident #1 was DNR. RN B stated it was expected to follow the resident's wishes of the directive. RN B stated PCC showed DNR and that was followed. During an interview with FM #1 on [DATE] at 2:00 PM, FM #1 stated RN A stated to her when Resident #1 expired that he was DNR. The FM stated the last she knew Resident #1 was DNR and he did not tell her he was a full code. The FM stated all along she thought DNR was what Resident #1 had wanted. The FM stated she was blown away that EMS was right there with Resident #1 and could have possibly saved him. The FM stated RN A told her Resident #1 died immediately and there was nothing they could have done for Resident #1 because he was DNR. The FM stated she was so upset the facility had messed up and did not grant Resident # 1 his wishes he had requested. The FM stated the facility dropped the ball with Resident #1. During an interview with the DON on [DATE] at 6:22 PM, she stated she started with the facility on [DATE]. The DON stated she was not at the facility when Resident #1 had expired. The DON stated the current MDS Coordinator was not working in the facility during the time of the incident with Resident #1. The DON stated the MDS Coordinator would have been responsible for making the change of the DNR to full code. It was expected for the MDS Coordinator to make the change to make sure Resident #1's wishes were honored. The DON stated Resident #1's rights were not honored when his code status of DNR to full code were never changed after Resident #1 requested. During an interview with the ADM on [DATE] at 6:48 PM, the ADM stated the Prev MDS Coordinator would have been responsible for changing Resident #1's code status after the care plan meeting on [DATE]. The ADM stated Resident #1's code status was never changed from DNR to full code when Resident #1 had changed it from DNR to full code. The ADM stated it was expected for Resident #1's code status to be changed from DNR to full code when he requested at the care plan meeting. The ADM stated with the code status not being updated Resident #1's wishes were not get granted. Interview attempted with the Prev MDS Coordinator on [DATE] at 1:28 PM was unsuccessful. Left voice message for the Prev MDS Coordinator to return call. The Prev MDS never returned the call. Interview attempted with the Prev DON on [DATE] at 1:30 PM was unsuccessful. Left voice message for the Prev DON to return call. The Prev DON never returned call. Record review of the facility's policy, dated [DATE], revised [DATE], titled Advance Directives reflected. Advanced directives will be respected in accordance with state law and facility policy. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 7:42 PM. The ADM was notified. The ADM was provided with the IJ template on [DATE] at 7:42 PM . The following Plan of Removal submitted by the facility was accepted on [DATE] at 7:25 am: F678- The facility failed to ensure Resident #1 was provided CPR. [DATE] (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following actions were immediately put into place: A comprehensive review of all residents was conducted DON, ADON, and Corporate Clinical Specialists to verify code status, medical orders, care plan, and DNR documentation on [DATE]. Care plans were checked to ensure alignment with advance directive documentation DON, ADON, and Corporate Clinical Specialists on [DATE]. Advance directive binders at the nurses' station were cross-checked, with necessary adjustments made to DNR documentation by DON, ADON, and Corporate Clinical Specialists on [DATE]. DON/Designee will keep binders updated on ongoing basis. All staff were in-serviced on binder's kept at nursing station. An Ad Hoc QAPI was held on [DATE], to include Medical Director, DON, Administrator and Corporate Clinical Specialist. Inservice DON and ADON was completed by Corporate Clinical Specialist on [DATE] on the following: How to document, identify and update code status on residents. CCS/DON/Nursing Administration will in-service licensed staff on the following: How to document, identify and update code status on residents. Competency was validated by verbal quizzes. Any staff that were no in-serviced will not be able to work the floor until training and competency is validated by DON/Designee. Inservice was provided to all staff on how to identify code status by nursing admin on [DATE]. Competency validated by verbal quizzes. The above information will be included in new hire orientation by Administrator effective [DATE]. Monitoring and Audits: The Administrator /designee will conduct audits of advance directive documentation to ensure accuracy in electronic medical records (E.M.R.) weekly x 4 weeks. After 4 weeks, the Adm/Designee will follow the above process twice a month for 8 weeks, then monthly thereafter. Mock Code Drills: DON/designee will perform quarterly mock code drills for 1 year to ensure staff can effectively identify code status and respond correctly to emergencies . The facility QA Committee will meet weekly starting [DATE], for the next eight weeks to review compliance with the plan of action. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. Monitoring of the POR included the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the ADON on [DATE] at 12:30 PM, she stated she had in serviced over advanced directives with CCS on [DATE]. The ADON stated after she received her training, she assisted with training staff. The ADON stated a short quiz was conducted after the training and she passed the quiz. She stated she was trained making sure the Advanced Directive was in place, make sure the code status was entered in PCC under the resident's name, and to make sure the binder at the nurses' station stayed updated. During an interview with RN B on [DATE] at 12:57 PM, she stated she had received her training on [DATE] with the ADON over advanced directives. The ADON stated the Advanced Directives training included making sure code status was entered in PCC and making sure the binder at the nurse's station was updated with the code status. During an interview with RN C on [DATE] at 1:03 PM, she stated she was trained on [DATE] with the ADON over Advanced Directives. RN C stated the training was over code status and where you can find the code status in PCC. RN C stated the code status could also be found in the black binder at the nurse's station. During an interview with LVN D on [DATE] at 1:20 PM, she stated she was trained on [DATE] on advanced directives with the DON. LVN D stated she was trained on the location of finding the code status and making sure the code status was updated. LVN D stated code status would be located in the black binder at the nurse's station and in PCC . During an interview with LVN E on [DATE] at 1:29 PM, she stated the CCS trained her on [DATE] over advanced directives. She was in serviced on knowing the difference between DNR and full code. LVN knew code status was able to be located in PCC and in the black binder at the nurse's station. During an interview with Med Tech F on [DATE] at 1:40 PM, she stated she completed the training on Advanced Directives on [DATE] with the ADON. Med Tech F stated she was trained on finding the code status. Med Tech F stated the code status could be found in PCC and in the black binder at the nurse's station. During an interview with CNA G on [DATE] at 1:55 PM, she stated she completed the code states training on [DATE] with the ADON. CNA G stated the training was on the location of finding the code status. CNA G stated the code status could be located in the black binder at the nurse's station and in PCC. During an interview with CNA H on [DATE] at 2:00 PM, he stated he was trained on the code status on [DATE] with the ADON. CNA H stated he was trained on how to find the code status in PCC. CNA H stated the code status could also be found in the black binder at the nurse's station. During an interview with Med Tech I on [DATE] at 2:05 PM, he stated he was trained on the code status on [DATE] with the DON. Med Tech I stated he learned where to find the code status at the nurse's station in the black binder. Med Tech I stated he also learned where to find the code status in PCC. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on [DATE] at 2:30 PM, she stated she was trained on Advanced Directives on [DATE] by the CCS. The DON stated all facility staff training was completed on Advanced Directives on [DATE]. The DON stated all staff were trained on the location to find the code status on residents. The DON stated the comprehensive audit of all residents to verify code status, medical orders, and DNR documentation was completed on [DATE]. The DON stated all staff knew every resident had a right to have their wishes followed . During an interview with the ADM on [DATE] at 2:45 PM, she stated she completed her in service on [DATE] with the CCS over code status. The ADM stated all facility staff were trained on code status as of [DATE]. The ADM sated the code status audit were completed on [DATE], on all residents. The ADM stated the DON or a designee would be responsible for the audits and mock trials that will be conducted. The ADM stated any new staff will be trained at the new hire orientation. Record review of the comprehensive audit of all residents to verify code status, medical orders, and DNR documentation was completed on [DATE]. Record review of how to document and verify code status in service with all facility staff was completed on [DATE]. The ADM was informed the Immediate Jeopardy was removed on [DATE] at 3:11 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 7 residents (Residents #2) reviewed for medications and pharmacy services The facility failed to ensure Resident #2 received his hospital ordered medications when it was not documented whether Levofloxacin (a medication used for treating infections) and Metronidazole (a medication to treat various infections) were ordered when Resident # 2 discharged from the hospital to the facility on [DATE]. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medication or care to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Record review of Resident #2's face sheet, printed on 02/28/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident # 2 had diagnoses which included chronic respiratory failure (shortness of breath), congestive heart failure (heart does not pump blood as well as it should), chronic obstructive pulmonary disease (lung disease that block airflow making it difficult to breathe, diabetes (too much sugar in the blood), and cirrhosis of the liver (chronic liver damage from a variety of scarring and liver failure). Record review of Resident #2's admission MDS assessment, dated 12/21/2024, reflected no BIMS score was indicated. Record review of Resident #2's comprehensive care plan, dated 12/07/2024, reflected Resident #1 had Emphysema (chronic lung disease that permanently damages the lung air sacs, making it difficult to breathe). Record review of Resident #2's hospital discharge orders, dated 12/07/2024, reflected an order for Levofloxacin give 1 750 MG by mouth every day at noon for 27 days for infection and Metronidazole give 1 500 MG by mouth two times a day for infection. Record review of Resident #2's December 2024 MAR reflected in part, the Levofloxacin and Metronidazole had a x for dates 12/07/2024 through 12/15/2024. Resident #2 received his first dose of Levofloxacin on 12/16/2024 and first dose of Metronidazole on 12/15/2024. Record review of Resident #2's progress notes for 12/07/2024 through 02/14/2024, reflected no notes that indicated Levofloxacin and Metronidazole order from the hospital were placed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress notes, dated 12/15/2025, written by LVN K at 3:07 PM, reflected This LVN notified by NP to start Levaquin 750 MG QD (at noon) for 4 wks, Robaxin 500 MG TIB for muscle spasms, flagyl 500 MG BID for 4 wks, initial robaxin 500mg and levaquin 750MG given, Flagyl will start HS, this LVN notified DON or orders given. NP stated that the resident's inhaler and nebulizer treatment dosages and frequencies will be addressed tomorrow with the physician. NP stated she will see resident tomorrow in the facility. Record review of Resident #2's orders, dated 12/07/2024 , did not reflect Levofloxacin and Metronidazole. Record review of Resident # 2's hospital records, dated 12/21/2024, reflected Resident #1 was admitted to hospice and was diagnosed with the end stage COPD. Resident # 2 was his own responsible person. On 12/21/2024 at 6:03 PM, revealed Resident #2 complained of shortness of breath and was sent out to the hospital. Attempted interview with Resident # 2's FM on 03/01/2025 at 12:22 PM , a voice message was requesting a return call. The FM never returned call by exit on 03/03/2025. During an interview with the NP on 03/01/2025 at 1:02 PM, the NP stated Resident # 2 did not receive the Levofloxacin and Metronidazole when he admitted to the facility on [DATE]. Resident # 2 did not get the antibiotics ordered until 12/15/2024. The NP stated the two antibiotics were being used to see if it would clear Resident #2's lung lesion. The NP stated Resident #1 was loaded with antibiotics while in the hospital and she could not make a medical determination of Resident # 2 receiving the antibiotics late or even if received at the start date would have any type of adverse effect. The NP stated the hospital physician was trying to see what antibiotic would help with the lung lesions. The NP stated Resident # 1 was sent out to the hospital for shortness of breath on 12/212024 and not any issues with delay in receiving the antibiotics. During an interview with LVN K on 03/01/2025 at 2:36 PM, she stated she looked at the admitting paperwork for Resident #2 on 12/07/2024 and the order for antibiotics had not been placed. LVN K spoke with the NP, and she stated Resident # 2 was supposed to be on antibiotics when admitted to the facility on [DATE]. LVN K told the NP there was no orders for the antibiotics and the NP told her to go ahead and start the orders for Resident # 2. LVN K stated the orders for antibiotics Levofloxacin and Metronidazole was placed on 12/15/2024 . During an interview with LVN J on 03/01/2025 at 6:00 PM, she stated she admitted Resident # 2 on 12/07/2024 when he transferred from the hospital. LVN J stated she had recalled putting in a bunch of orders but did not recall any antibiotics. LVN J stated she was not a hundred percent she had put all of the orders in. LVN J stated it was expected to make sure all orders from the hospital discharge were entered when Resident #2 admitted to the facility . During an interview with DON on 03/1/2025 at 6:22 PM, she stated she started with the facility on 1/16/2025. The DON stated she was not working at the facility when the incident occurred. The DON stated it was expected for LVN J to make sure all the hospital orders when Resident # 2 was admitted . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADM on 03/01/2025 at 6:48 PM, the ADM stated all orders were placed in the system at admissions. The ADM stated it was expected for LVN J to have made sure all Resident #2's hospital orders were entered at admissions. The ADM stated not having orders placed could cause a delay in recovery. Attempted interview with the Prev DON on 03/02/2025 at 1:30 PM was unsuccessful. Left voice message for Prev DON to return call. The Prev DON never returned call . Record review of the facility's, undated, policy titled Medication Reconciliation for New Admissions and Readmissions reflected To ensure accurate medication management and promote patient safety during the admission and readmission process.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review the facility failed to ensure professional staff were licensed, certified, or registered in accordance with applicable state laws for 4 of 7 residents (Residents #1, #2, #3, and #4) reviewed for medication administration. The facility failed to ensure Med Tech M had a current and active license. Med Tech M provided medications to Residents #1, #2, #3, and #4 while her Med Tech license was expired from [DATE] through [DATE]. This failure could place residents at risk for inadequate care and/or services. Findings include : 1. Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included heart failure (heart does not pump as well as it should), diabetes (body have trouble controlling blood sugar energy) and hypertension (high blood pressure). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated intact cognition. Resident #1 could make himself understood and was able to understand verbal content. Record review of Resident #1's care plan, dated [DATE], reflected Resident #1 was care planed for CHF. 2. Record review of Resident #2's face sheet, printed on [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident # 2 had diagnoses which included chronic respiratory failure (shortness of breath), congestive heart failure (heart does not pump blood as well as it should), chronic obstructive pulmonary disease (lung disease that block airflow making it difficult to breathe, diabetes(too much sugar in the blood), and cirrhosis of the liver (chronic liver damage from a variety of scarring and liver failure). Record review of Resident #2's admission MDS assessment, dated [DATE], reflected no BIMS score was indicated. Record review of Resident #2's comprehensive care plan, dated [DATE], reflected Resident #1 had Emphysema (chronic lung disease that permanently damages the lung air sacs, making it difficult to breathe). Record review of Resident #2's care plan, dated [DATE], reflected Resident #2 was care planed for COPD. 3. Record review of Resident #3's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included hypertension (high blood pressure), diabetes (too much sugar in the blood), and depression(sad). (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 3's quarterly MDS, dated [DATE], reflected a BIMS score of 10, which indicated moderate cognitive impairment. Record review of Resident #3's care plan, dated [DATE], reflected Resident #3 was care planned that she had depression. 4. Record review of Resident #4's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included heart failure (heart does not pump blood well as it should), diabetes (too much sugar in the blood) and COPD (development of right-sided heart failure). Record review of Resident #4's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated cognitive intact. Record review of Resident #4's care plan, dated [DATE], reflected Resident #4 was care planned for heart failure. Record review of TULIP, dated [DATE], reflected Med Tech M's license was originally issued on [DATE] , expired on [DATE] and currently issued on [DATE]. Record review of Med Tech M's timecard from [DATE] to [DATE] reflected Med Tech M passed medications with her license expired on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Record review of Medication error tracking form, dated [DATE] to [DATE], did not reflect any medications errors for Med Tech M. During an interview with Med Tech M on [DATE] at 2:28 PM, she stated she did not know her license had expired. Med Tech M stated she thought she had until [DATE] to renew her license. Med Tech M stated the HRR told her license had expired in November. Med Tech M stated she could not recall how long the license had been expired or the date she renewed them. Med Tech M stated, she did not know, and she was not able to answer if she felt it was okay to pass medications when her license had expired . Med Tech M was asked what adverse effect could occur giving medications with an expired license, Med Tech M kept repeating she thought she had until April. Med Tech M was asked why she thought she had until April to renew her license and she was not able to give a valid reason. Med Tech M appeared very nervous and kept repeating she thought she had until April when questions were asked. During an interview with the HRR on [DATE] at 10:45 AM, the HRR stated Med Tech M was responsible for keeping up with the license renewal. The HRR stated she was not tracking the licenses prior to the incident with Med Tech H . The HHR stated that she would be responsible for tracking licenses. The HHR stated a spreadsheet was now used for tracking of licenses. The HRR stated the ADM brought it to her attention on [DATE] when she discovered Med Tech M's license was expired. The HHR stated Med Tech M passed medications 8 days when her license was expired. The HHR stated Med Tech M was immediately removed from passing meds until her license was renewed. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on [DATE] at 6:22 PM, she stated she started with the facility on [DATE]. The DON stated she was not working at the facility when Med Tech M's license had expired. The DON stated she heard about it when she first started working at the facility and a query was ran on if any errors had occurred with Med Tech M. The DON stated there was no errors but even with an expired or active license anything could happen with a med pass. The DON stated it was not proper protocol for Med Tech M to have administered medications when her license expired. The HRR would be responsible for making sure Med Tech M license were up to date . During an interview with the ADM on [DATE] at 6:48 PM, she stated she placed the certification expiration dates on the staff schedules when she noticed Med Tech M license had expired on [DATE]. The ADM stated Med Tech M passed medications a total of 8 days when it was discovered her license had expired. The ADM stated Med Tech M was immediately removed from passing medications on [DATE] until her license was renewed on [DATE]. The ADM stated HRR was immediately contacted about the expired license. Med Tech M was expected to notify the HRR that her license expired and immediately stopped passing meds. The ADM stated the HRR was responsible for making sure licenses had not expired. The ADM stated it was not practice for Med Tech M to have passed meds with an expired license. The ADM stated passing meds whether active or expired license could have possible med errors. Interview attempted with Prev DON on [DATE] at 1:30 PM was unsuccessful. Left voice message for Prev DON to return call. Prev DON never returned call before the exit . Record review of the facility's, undated, policy titled Texas Nursing License/Certification Verification reflected Please ensure that there is system on place for license/certification verification upon hire and tracking of the expiration dates. Once the verification is completed upon hire, it should de documented on the Texas Licensed Verification form. This form can be found on the I drive under Human Resources. Applicant or Pre-Hire, Tx-Additional, and completed document should be placed in a binder by month order, based on the month the license/certification expires. Prior to the month of the expiration, verification must occur.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review, the facility failed to develop policies and procedures to ensure each resident was offered an influenza immunization October 1 through March 31 annually, unless the immunization was medically contraindicated or the resident had already been immunized during this time period and before offering the pneumococcal immunization, each resident was offered a pneumococcal immunization, unless the immunization was medically contraindicated or the resident had already been immunized for 2 of 7 residents (Resident #3 Resident #4) reviewed for immunizations . The facility failed to document the flu vaccine for Resident #3 and Resident #4 which resulted in double flu vaccinations. This failure could place residents at risk of not receiving necessary medical care and hospitalization . Findings include: 1. Record review of Resident #3's face sheet, dated 03/01/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included hypertension (high blood pressure), diabetes (too much sugar in the blood), and depression (sad). Record review of Resident 3's quarterly MDS, dated [DATE], reflected a BIMS score of 10, which indicated moderate cognitive impairment. Record review of Resident #3's care plan, dated 03/01/2025, reflected Resident #3 was care planned that she received the vaccine Influenza on 11/19/2024. Record review of Resident #3's immunizations reflected the flu shot was given on 11/20/2024. Record review of Resident #3's incident report reflected the flu shot was given on 11/20/2024 at 6:48 AM by RN L. Record review of Resident #3's progress note did not reflect any documentation that a flu shot was given prior to 11/20/2024. Record review of Resident #3's progress note, written by RN L on 11/20/2024 at 7:22 PM, reflected monitoring Resident #3 for adverse reaction from flu vaccine. None noted. Pleasant and at normal baseline for all ADL's Appetite good. 2. Record review of Resident #4's face sheet, dated 03/01/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included heart failure (heart does not pump blood well as it should), diabetes (too much sugar in the blood) and COPD (development of right-sided heart failure). Record review of Resident #4's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated cognitive was intact. (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's care plan, dated 03/01/2025, did not reflect Resident #4's vaccine Influenza on 11/19/2024. Record review of Resident #4's immunizations reflected the flu shot was given on 11/19/2024. Record review of Resident #4's incident report reflected the flu shot was given on 11/19/2024 at 4:41 PM by RN L. Record review of Resident #4's progress note did not reflect any documentation that a flu shot was given prior to 11/19/2024. Record review of Resident #4's progress note written by RN L on 11/20/2024 at 7:48 PM reflected no adverse reactions from flu vaccine on 11/19/2024. At normal baseline. During an interview with the NP on 03/01/2025 at 1:02 PM, the NP stated there would not be any adverse effect for Resident # 3 and Resident #4 receiving double flu shots. The NP stated it could be some soreness to the arm from receiving the shot. During an interview with Resident #3 on 03/01/2025 at 1:32 PM, the resident stated she received the flu shot but was not able to recall the date it was received. Resident #3 stated she could not recall if she had received two flu shots and she was not sick from receiving the flu shot when she had received it. During an interview with Resident #4 on 03/01/2025 at 1:45 PM, the resident stated she received her flu shot a couple months ago but did not recall getting two shots. Resident #4 stated she was not sick when she received the flu shot. During an interview with RN L on 03/1/2025 at 1:38 PM, she stated she worked weekends on 11/19/2024 and 11/20/2024. RN L stated Resident # 3 and Resident #4 were not documented that they had been given the flu shot. RN L stated if it was not documented it meant it did not get done. The RN administered the flu vaccine to Resident #3 on 11/20/2024 and Resident # 4 on 11/19/2024. The RN stated the Prev MDS coordinator had written paperwork that Resident #3 and Resident #4 had received their flu shot during the clinic back in October. During an interview with the DON on 03/1/2025 at 6:22 PM, she stated she started with the facility on 1/16/2025. The DON stated she was not working at the facility when the incident occurred with the flu shots given twice to Resident #3 and Resident #4. The DON stated it was expected for the flu shot to be updated in PCC. The DON stated by giving a double dose could cause a sore arm or illness depending on the residents' health condition. During an interview with the ADM on 03/01/2025 at 6:48 PM, the ADM stated there was a flu clinic at the end of October 2024, the date not recalled, Resident #3 and Resident #4's flu shot that was given was documented on paper. The Prev DON who assisted with the clinic no longer worked at the facility as of November 2025. The ADM stated Resident #3 and Resident #4's flu shot administered at the end of October did not get uploaded to PCC. The ADM stated Resident # 3 and Resident #4 received double flu vaccines because it was not documented in PCC that it was received. The ADM stated it was expected for the flu vaccines to be documented in PCC to show that it had been given. The ADM stated depending on a resident's medical condition could cause illness from double flu vaccines. (continued on next page)

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	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lily Springs Rehabilitation and Healthcare Center	901 Central Texas Expwy Lampasas, TX 76550

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview attempted with Prev MDS Coordinator on 03/02/2025 at 1:28 PM was unsuccessful. Left voice message for Prev MDS Coordinator to return call. Prev MDS never returned call before exit. Interview attempted with Prev DON on 03/02/2025 at 1:30 PM was unsuccessful. Left voice message for Prev DON to return call. Prev DON never returned call before the exit. Record review of the facility's, policy dated 07/08/2024 and reviewed 04/01/2019, titled Medication Administration reflected If a dosage is believed to be inappropriate or excessive for a resident , or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident attending physician or the facility medical director to discuss the concerns.