

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 11/19/2025
NAME OF PROVIDER OR SUPPLIER Lily Springs Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Central Texas Expwy Lampasas, TX 76550	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain the residents' freedom retain and use personal possessions for one (Resident #1) of one resident reviewed for personal property. The facility failed to allow Resident #1 to have a powered wheelchair because she had display aggressive behaviors. This failure could place resident at risk of not being able to retain personal property, at risk of feeling disrespected, having reduced dignity and diminished quality of life. Findings included: Record review of Resident #1's undated Clinical sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (damage occurred in the right side of the brain, as the brain's right hemisphere controls the left side of the body), heart failure, unspecified (a general diagnosis of heart failure without further detail about its type or cause), muscle weakness (generalized) (a decrease in overall muscle strength that affects multiple muscle groups throughout the body), difficulty in walking, not elsewhere classified (a patient's inability to walk effectively when a more specific diagnosis is not yet available, such as a particular neurological condition, musculoskeletal issue, or specific type of abnormal gait), unspecified lack of coordination (a difficulty in performing smooth, controlled movements when the specific cause or type of coordination problem is not identified or documented), unsteadiness on feet (a lack of stability while walking or standing, characterized by symptoms like stumbling, difficulty with balance, a broad or staggering walk, or feeling rooted to the ground), need for assistance with personal care (the inability of an individual to independently perform daily self-care activities, such as bathing, dressing, grooming, and toileting, due to a physical or cognitive impairment, illness, or temporary condition), adult failure to thrive (a complex syndrome, not a specific disease, characterized by unexplained weight loss, malnutrition, and a decline in functional ability, leading to increased disability and potential premature death), alcohol abuse with other alcohol-induced disorder (a persistent pattern of alcohol use that leads to significant impairment or distress). Record review of Resident #1's comprehensive MDS assessment, dated 08/06/2025, Section C (Cognitive Patterns) reflected a BIMS score of 15, which intact cognition. Record review of Resident #1's care plan initial dated 5/30/2025 and revised on 7/22/2025, reflected Focus: she has a history of Trauma and ongoing anger issues resulting in verbal outbursts. Known triggers are loud noises, overstimulation, and peer interactions, partial denial of issues and reluctant participation in care planning. Currently working with LCSW and on medication regimen for emotional regulation. Goal: Resident #1 will inform staff of any increased levels of anxiety/depression or exposure to identified triggers. Resident will participate in scheduled therapy sessions with LCSW to address root cause or trauma and anger. Resident will demonstrate reduced frequency of angry outbursts in the dining room and other communal areas. Resident #1 will report feeling emotionally and safe environment. Intervention: Engage resident in ongoing sessions with LCSW to address trauma and anger. Monitor and document triggers such as loud noises, overstimulation, and irritating peer interaction. Offer calm quiet environment. Reinforce consistent medication administration as ordered to support emotional regulation. Educate staff on Trauma-informed approach and environmental sensitivity for Resident #1. Revisit Care Plan with resident regularly to promote engagement and reinforce care plan preferences and being respected. Give meds, psych services as ordered, staff will offer support and encouragement. During an interview with the Resident #1 on 9/17/25 at 2:57 pm stated she felt safe living at the facility. Resident #1 stated she was going to get a power wheelchair, but she doesn't know why the facility staff keeps telling her she cannot have one. Resident #1 stated she was pushing herself in her own wheelchair. She stated she was holding on to someone else's chair, and they stopped, and she fell. She stated she was cussing up a storm. She hit her nose and arm. EMS was called and the police came. Resident #1 stated the staff, and LE stated she was drunk. Resident #1 stated LE gave her the option to either go to the hospital or go to jail. She stated if she had her own chair she would have not fallen. She stated her right shoulder was bad. She thinks therapy was prejudice against her because she was aggressive. She was not able to have a drink anymore. During an interview with the DON on 9/17/25 at 4:42 pm stated Resident #1 had a history of being aggressive. She had a past of driving a car and being aggressive. He stated the PsyD she suggested that she does not have an electric wheelchair. DON stated she thought she could become aggressive towards other residents while utilizing the motorized wheelchair. DON stated they were going to have a care plan meeting, and the PsyD will be in the meeting. During an interview with the ADON on 9/19/25 at 1:10 pm stated Resident #1 had</p>		