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	05/19/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm 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** 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, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Residents #1) reviewed for care plans. The facility failed to have a comprehensive person-centered care plan for Resident #1 to address herbehavior of banging on the wall of her room that occurred on 05/05/2026 and two other times, dates unknown. This failure could place residents at risk of not receiving care and services to meet individualized, behavioral, medical and nursing needs.Findings included: Record review of Resident #1's face sheet, undated, revealed a ninety year-old female who was admitted to the facility on [DATE] with a diagnosis that included Alzheimer's Disease (a progressive neurodegenerative brain disorder and the most common cause of dementia), major depressive disorder (a serious mood disorder characterized by persistent feelings of sadness, a loss of interest in activities, and low energy that significantly disrupt daily functioning), and anxiety disorder (mental health condition characterized by excessive, persistent, and disproportionate fear or worry in everyday situations). Record review of Resident #1's care plan revealed no focus or interventions for behaviors of Resident #1 banging or hitting the walls in her room. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 05/06/2026 Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 5 indicating severe cognitive issues. Record review of Resident #1's General Nurses Notes - narrative by LVN A dated 05/06/2026 reflected Resident #1 was highly agitated during shift and Resident #1 was closed fist banging on the wall. Resident #1 continued to not want staff in the room while also continuing to bang on the bedroom wall. Record review of Health and Human Services Facility Provider Investigative Report dated 05/12/2026 Intake number 1089942 injury of an unknown origin reflected, upon observation resident noted to have a bruise across her right eyebrow and bruising noted to her right forearm X3. All three bruises noted to have a scab over the center of them, and resident was unable to give description of the events. Skin assessment completed noting all new skin. Facility investigative summary reflected, Banging her first against the wall may have contributed to bruising on the forearm. During an interview on 05/19/2026 at 12:53 PM LVN A said on 05/06/2026 Resident #1, who lived in the facility secured unit, was closed fist banging on the wall. LVN A said Resident #1 had a significant history of banging on the walls. LVN A said Resident #1 had three incidents that LVN A knew about that Resident #1 banged on the wall of her room. LVN A said Resident #1 should be care planned for banging on the walls of her room because it was Resident#1's form of communication. LVN A said all staff members knew when Resident #1 was banging on the wall it was to get the attention of everyone in the building. LVN A said Resident #1 could potentially be harmed because she banged on the wall. LVN A said she had not told the MDS coordinator about Resident #1 banging on the wall of her room. LVN A said a care plan was a form of charting that was related to the whole healthcare for the residents. She said a care plan was something that helped (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff understand how the residents communicated, what their care needs were, and how to better help residents. She said the possible negative effect of not-care planning for Resident #1's banging on the wall behavior was that staff would not have to have knowledge of the situation to apply critical thinking and realize how to intervene and prevent Resident #1 from injuring herself. During an interview on 05/19/2026 at 1:40 PM with the CCS he said Resident #1's history of beating on the walls should be care planned. He said it should be care planned so staff could be aware of the behavior and anyone who was unfamiliar with Resident #1 could be aware of the behavior. The CCS said a care plan was a listing of everything about that resident and what was particular to that resident. The CCS said anyone could do a care plan but if the MDS coordinator was not told about something that needed to be added to a resident's care plan it might not be added. He said the possible negative effect of Resident #1's behavior of beating on the walls of her room would be that a staff member would not know this behavior. The CCS said if staff knew this behavior from the care plan it might have helped in the understanding of Resident #1. The CCS said the MDS coordinator was responsible for entering items into resident care plans and staff told her about behaviors to be added. The CCS said the behavior of Resident #1 beating on the walls of her room could include more specific intervention regarding her safety and wellbeing. During an interview on 05/19/2026 at 2:59 PM with the ADON she said a care plan showed a description of resident ADLs and anything about the care for the residents including wound care and behaviors. The ADON said a care plan was important because it showed how to care for a resident and included interventions. She said care planning was not her area. She said Resident #1's behavior of her banging on the wall should be care planned. The ADON said a CNA should tell a nurse about the resident behavior so a nurse could add it to the care plan. ADON said nursing was responsible for care plans. The ADON said a possible negative effect of not care planning was missing out on any needed care that could possibly not have a good outcome for the residents. Record review of facility Care Plan Policy dated August of 2006 reflected that the care plan shall be used in developing the residents daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation Completed care plans are placed in the resident's chart and/or in a 3-ring binder located at the appropriate nurses' station. The Nurse Supervisor uses the care plan to complete the CNAs daily/weekly work assignment sheets and/or flow sheets.CNAs are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. Other facility staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and/or the MDS Assessment Coordinator. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made.Documentation must be consistent with the resident's care plan.