

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 05/05/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide reasonable accommodations to meet the needs and preferences for 1 of 6 residents reviewed for accommodations.</p> <p>The facility failed to ensure that Resident #47 had the call light device in reach while lying in bed.</p> <p>The facility failed to accommodate Resident #47 with a call light device that would meet their individual needs.</p> <p>This deficient practice could affect and diminish the resident's quality of life by potentially placing the resident at risk of injury, not receive timely care or receive nursing interventions to meet the resident's needs.</p> <p>Findings include:</p> <p>Record review of Resident #47's Face Sheet dated 04/16/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis that included Sepsis (condition that occurs when the body's response to an infection causes injury to its own tissues and organs), Kidney Failure (condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite), Contracture of Muscles; right hand and left wrist (abnormal shortening of muscle tissue that makes the muscle highly resistant to stretching), Dysphagia (difficulty swallowing), Cognitive Communication Deficit (difficulties in communication that arise from impairments in cognitive processes such as attention, memory, perception, and executive function), Delusional Disorder (fixed, false conviction in something that is not real or shared by other people), Depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities once enjoyed), Anxiety (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), Psychosis (is a mental health condition characterized by a disconnection from reality), Paroxysmal Atrial Fibrillation (is an irregular heart rhythm that can cause symptoms including fatigue, lightheadedness, and stroke), and Spinal Stenosis (narrowing of spaces in the spine).</p> <p>Record review of Resident #47's quarterly Minimum Data Set, dated [DATE] reflected a Brief Interview for Mental Status Score of 99, which indicated severe cognitive impairment.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #47's Care Plan dated 02/26/2025 reflected Resident #47 required extensive assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #47 to maintain current level of function with assistance in his daily living care needs.</p> <p>Record review of Resident #47 Care Plan dated 02/26/2025 stated for the facility staff to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. Resident #47 needs prompt response to all requests for assistance.</p> <p>In an observation on 04/14/2025 at 9:59 AM of Resident #47 the call light button was out of reach located on the right side of the resident's bed laying on the floor. Resident #47 was observed to have contracted hands. There was no observation of additional call light pad button device for the resident. The resident was not interviewable.</p> <p>In an observation on 04/15/2025 at 12:17 PM of Resident #47, the call light button was clipped on the resident's right side of the bed in which it was out of reach due to resident having contracted hands. During the observation, there was no visual of a call light pad button device on his chest in order to assist and accommodate the resident's needs.</p> <p>In an interview on 04/15/2025 at 12:25 PM with LVN A, stated Resident #47 should have a call light pad button device on his chest. LVN A went and checked on Resident #47 herself stated the resident did not have a call light pad button device. LVN A advised that it will be brought up with facility staff and she would have it taken care of right away.</p> <p>In an interview on 04/16/2025 at 11:43 AM with MA G, she stated Resident #47 had not used the original call light button system set in place and there was not a call light pad button used prior. MA G stated Resident #47 would benefit from a call light pad button device on his chest for easier usage as he has contracted hands and was unable to reach. MA G stated a negative effect on the resident would be that he cannot push the call light button for assistance.</p> <p>In an interview on 04/16/2025 at 11:45 AM with Responsible Party, she stated Resident #47 did have the capability to use the original call light button device. Responsible Party stated a call light pad button device would be easier for Resident #47 to utilize in the events of daily assistance and needing it in the event of an emergency considering he has contracted hands.</p> <p>In an interview on 04/16/2025 at 12:15 PM with LVN A, stated Resident # 47 was able to manage pushing the call light pad button device now set in place since it's located on his chest in easy reach. LVN A stated if there was an issue prior before with the resident, they would have missed it. LVN A stated some effects of not having the appropriate call light button system set in place was the resident not able to push it for assistance and staff are unable to meet the resident's needs in which can pose effects on the resident's quality of life.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/16/2025 at 2:20 PM with Director of Nursing (DON), stated if a resident had the call light button device on the floor and if that resident had contracted hands, the resident would not be able to reach the call light button device nor potentially be able to use it in which the call light pad button device would be easier for the resident to use such as, Resident #47. The DON stated her expectations for call light devices are to be within reasonable reach of residents and assessing residents for call pads or accommodation needs. The DON stated resident's quality of life can be affected, but it would depend on the resident.</p> <p>In an interview on 04/16/2025 at 2:50 PM with Administrator, she stated staff are responsible for having call light devices in appropriate reach for residents. Administrator stated that herself and DON are in charge of making sure that the residents have the appropriate call light device system set in place for their individual needs. Administrator stated, the original call light button device for Resident #47 was not feasible, and the call light pad button device set in place now was more feasible for the resident. Administrator stated her expectations for call light device systems was for all residents to have a functioning call light button device that residents can use to meet their individualized needs. Administrator stated resident's quality of life can be affected if they don't have access to call light button device due to not getting attention or their needs met, or it can make a resident feel neglected affecting their mental health.</p> <p>Record review of Accommodation of Needs Policy stated: the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. Policy Interpretation and Implementation; The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Examples of such adaptations may include providing access to assistive devices.</p> <p>Record review of Resident Call System Policy stated: residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation;</p> <p>Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Call system communication may be audible or visual. The system may be wired or wireless. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement abuse reporting policies for one (Resident #51) of five residents reviewed for abuse and neglect.</p> <p>The facility failed to implement policies that required reporting of major injury after an incident on 01/17/25 where Resident #51 fell out of the shower chair while transporting back to his room from the shower and sustained a fracture to the right femur.</p> <p>This deficient practice could place residents at risk of continued abuse and neglect if abuse policy is not properly implemented.</p> <p>Findings included:</p> <p>Record review of Resident #51's face sheet dated 04/16/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included unspecified fracture of the right femur, chronic obstructive pulmonary disease(a disease that makes it hard to breath and causes lung deterioration, morbid obesity, fall from non-moving wheelchair, and osteoarthritis (arthritis of the bones which causes widespread generalized pain.)</p> <p>Record review of Resident #51's care plan revised 02/12/25 reflected Resident #51 has impaired visual function related to legal blindness, had a right femur and right tibia fracture related to fall with interventions to initiate PT, OT, and pain treatment as indicated by MD.</p> <p>Record Review of Resident #51's MDS dated [DATE] indicated a BIMS score of 15 indicating intact cognition, a mood interview score of 5, and extensive assistance for bed mobility, transfers, and toilet use. He required two person assist for transfers between surfaces; MDS states this excludes to/from bath and toilet. Resident #51 had received 150 minutes of physical therapy starting on 01/22/25 and ended 02/28/25.</p> <p>Review of Resident #51's incident report dated 01/17/2025 at 11:12 am reflected the following, This nurse seen when resident fell out of the shower chair while shower aid was bringing him back to his room from just receiving a shower. EMS has been called and are here at the facility as the resident states he thinks he broke his right knee. Daughter has been contacted a few times without success will attempt to contact later. MD aware. Incident and vitals initiated at this time.</p> <p>Resident stated, I think I heard a loud pop. I think I broke my right knee.</p> <p>A section within the incident report titled, Other Info, reflected the following, Resident was being transported to a room after a shower. Resident states he adjusted himself in chair and although he was not completely settled, he told CNA he was ready to go back to his room. Resident and staff educated on importance of sitting properly in chair prior to transporting.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #51's discharge placement sheet from hospital dated, 01/18/25 reflected, Resident #51 is a [AGE] year old right-hand dominant male with a past medical history reported by the patient to have morbid obesity, CHF, Afib, congenital hydrocephalus (blindness), HTN, OSA who presents with a right distal shaft femur fracture after falling out of the shower chair at the nursing home today. He said that the while sitting on the chair the wheels broke down and he fell to the ground with his knee bent underneath him. Injury occurred at Lily Spring Nursing home. He reports experiencing immediate pain, gross deformity, and inability to bear weight about his right distal thigh after the accident. Patient was initially taken to the ER where x-rays were obtained and then a decision was made to transfer the patient by ambulance to hospital for further evaluation and care. Preliminary x-rays were obtained revealing the above-mentioned fracture(s)/injury(s) and Orthopedic surgery was consulted.</p> <p>It is also noted, (Resident #51) says fall was mechanical when was accidentally pushed out of wheelchair.</p> <p>Review of facility's record in TULIP reflected the incident was not reported to the State Agency. A complaint was filed by Resident #51 alleging neglect due to his fracture on 03/28/25.</p> <p>During an interview on 04/14/25 03:47 PM Resident #51 stated that he fell out of the shower chair in January of 2025. He stated he was in the hospital for 3 days and came back to receive physical therapy that had been working. He stated that the wheels were not properly functioning, and he tipped forward with his leg underneath him. He did have a pending litigation with the facility. If the facility had been more responsive to what happened to him, he would not bring legal action against the facility.</p> <p>During an interview with the Corp N. on 04/16/25 10:28 AM revealed they did not report the incident to the State Agency. They did an in-house investigation to rule out neglect. She mentioned she investigated the incident in the event that there was pending legal action, which there was none. She stated that the fall was witnessed so they did not say abuse. They ruled out neglect earlier and major bodily injury was not sign of neglect according to her policies. She stated they checked the wheelchairs and did an in-service to retrain everyone.</p> <p>During an interview with MA G on 04/16/25 at 11:33 am she stated that she was down the hall when the incident happened. She stated it was a big deal and seemed like it should have been a reportable incident because he went to the hospital. She stated they were in-serviced, the shower chairs were maintenance. She noted Resident #51 telling her he was filing a lawsuit against the facility, and she had helped him fill out the forms and gather information for his lawyers.</p> <p>During an interview with LVN A on 04/16/25 at 12:45 pm, she stated that she was unaware if there was a pending lawsuit. She was a witness to the incident, and she did not suspect abuse or neglect. She stated the wheel of the chair just gave out. She thought any fracture should be reported to the state. She had received many in-services on abuse and neglect and knew the ADM was the abuse and neglect coordinator. She noted that if she had known it wasn't reported to the State she would have reported it.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with DON on 04/16/25 at 2:30 pm she said that the abuse and neglect coordinator was the ADM. She stated she does not know Texas law for reportable yet. She stated that any event needs to be reported if it's within the law. She stated the event with Resident #51 happened on her second day and she was not involved in the incident.</p> <p>During an interview with ADM on 04/16/25 at 3:01 pm revealed that she did not report to the stated because she believed the fall was witnessed and the facility had done their due diligence ruling out abuse and neglect within the two-hour period. They had checked that the weight limit was under his weight and verified that the aid had not done anything wrong. They were able to clear it in-house. According to her it was not suspicious. They didn't report it within two hours of learning about the injury because they weren't aware it was a major injury until he arrived back at the facility. She stated that it was not up to the state to be the determining factor if an injury was considered neglect.</p> <p>5/3/25 10:00 AM Initial facility walk-thru revealed 7 residents up in wheelchairs to be sitting in common area next to nurse station watching television. All residents appeared neatly groomed. Further observation revealed 2 residents in wheelchairs near medication cart. One resident having vitals taken by RN A second resident receiving medications from MA G . CNA I sitting outside of room [ROOM NUMBER] for resident providing one to one sitting. CNA I stated she has provided one-to-one yesterday and today. Observation of resident coming down 200 hall walking with rolling walker to common area to watch television. Observation of housekeeping staff on 300 hall cleaning rooms.</p> <p>Record review of in-service of Safe Transport Practices-Shower Chair Safety and Response revealed 37 staff members have documentation of receiving in-service.</p> <p>In an interview on 5/3/25 at 2:41 PM with CNA J revealed CNA J stated she has received ANE in-service recently. CNA J states ANE is reported to the charge nurse and the ADM. CNA stated any suspicion of ANE is to be reported. CNA J stated if a resident falls either witnessed or unwitnessed then that is also to be reported to the charge nurse and the ADM. CNA J stated she recently received an in-service on safe transporting with the shower chairs. CNA J stated the shower chair needs to be inspected prior to use by the staff member and if the chair does not roll properly or is any form of disrepair then it should not be used and it should be reported to the charge nurse and maintenance. CNA J states if a resident shifts or slides while in shower chair then the staff member should get help from another staff member to readjust resident before continuing transport.</p> <p>In an interview on 5/3/25 at 3:00 PM with CNA I revealed CNA I stated she had recently received an in-service about abuse neglect and exploitation and who to report to. CAN I stated any concerns would be reported to the ADM. CNA I stated all falls are reported to the charge nurse and the ADM. CNA I stated she had received an in-service about safe transport with the shower chairs. CNA I states the shower chairs are to be inspected for safety before using with a resident. CNA I states if the shower chair is unsafe then it is to be reported to the charge nurse and the ADM. CNA I stated she thinks there is a book where it is documented and reported to maintenance, but she is not positive as she has never had to complete a work order or document on any unsafe equipment. CNA I stated if she had a resident in a shower chair and they started to slide out or readjusted and became unstable she would stop and try to secure the resident and call out for assistance from another staff member if needed.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 05/04/25 from 11:30 am - 5:15 pm 3 Housekeeping, 2 maintenance, 2 cooks, 2 RNs, 8 LPN/LVN, and 20 CNAs from different shifts all stated they were in-serviced before working their shift. Their in-service included when to report abuse, the types of abuse, examples of abuse and that covered that employees are free from retaliation if they report abuse.</p> <p>Interview with Corp N. on 05/04/25 at 2:30 pm she stated that she in-serviced the ADM, DON, ADON, MAINT on reporting requirements for abuse and neglect, reviewed the provider reports and facility policy for abuse and neglect reporting.</p> <p>Interview with RDO on 05/04/25 at 2:39 pm, she stated she in-serviced the DON and ADM on reporting and requirements for reporting. She reviewed what consisted a serious injury and reviewed the provider letter and corporate policy with them.</p> <p>Interview with MAINT on 05/04/25 at 2:41 pm, he stated he was in-serviced by the Corp. N. about the facility's abuse and neglect policy.</p> <p>Interview with ADON on 05/04/25 at 2:55 pm, she state that she was in serviced on abuse and neglect, the facility abuse coordinator, and what events are reportable.</p> <p>Interview with DON on 05/04/25 at 3:05 pm revealed she was in serviced on abuse and neglect, reporting timelines, retaliation for reporting, and the facilities abuse and neglect policy.</p> <p>Record review of Staff In-service training record revealed that ADM, ADON, DON, and MAINT were in-service by Corp. N on abuse and neglect on 05/02/25.</p> <p>Record review of New Hire Orientation paperwork packet on 05/04/25 revealed abuse and neglect reporting were apart of the education and orientation.</p> <p>Record review of statement provided on 05/04/25 revealed an AD HOC QAPI plan meeting took place on 05/02/25 that included ADM, DON, ADON, and Medical Director.</p> <p>Review of facility policy titled, Abuse Prohibition Policy, reviewed May 17, 2024.</p> <p>2. The facility will report all allegations and substantiated occurrences of abuse, neglect or misappropriation of resident property to the state agency and to all other agencies as required by law and will take all necessary corrective actions depending on the results of the investigation. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within two hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries.</p> <p>a.Initial Reporting</p> <p>i.Facility must provide sufficient information to describe the alleged violation and indicate how residents are being protected. Information should include, but is not limited to:</p> <p>1.Basic facility information</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all allegations involving abuse, neglect, or serious bodily injuries were reported immediately but not later than 24 hours after the allegation was made for one (Resident #51) of five residents reviewed for abuse and neglect.</p> <p>The facility failed to report to the State Agency an incident on 01/17/25 where Resident #51 fell out of the shower chair while transporting back to his room and sustained a fracture to the right femur.</p> <p>This deficient practice could place residents at risk of abuse and neglect.</p> <p>Findings included:</p> <p>Review of Resident #51's face sheet dated 04/16/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included unspecified fracture of the right femur fall from non-moving wheelchair, and osteoarthritis (arthritis of the bones which causes widespread generalized pain.)</p> <p>Review of Resident #51's MDS updated March 2, 2025 indicated he needed extensive assistance for bed mobility, transfers, and toileting. MDS indicated he received physical therapy for 150 minutes a week that began 01/22/25 and ended 02/28/25.</p> <p>Review of Resident #51's care plan revised 02/21/25 reflected Resident #51 has impaired visual function related to legal blindness, had a right femur and right tibia fracture related to fall with interventions to initiate PT, OT, and pain treatment as indicated by MD.</p> <p>Review of Resident #51's incident report dated 01/17/2025 at 11:12 am reflected the following, This nurse seen when resident fell out of the shower chair while shower aid [sic] was bringing him back to his room from just receiving a shower. ISNIP has been informed, EMS has been called and are here at the facility as the resident states he thinks he broke his right knee. [family] has been contacted a few times without success will attempt to contact at a later time. MD aware. Incident and vitals initiated at this time. Resident stated, I think I heard a loud pop. I think I broke my right knee.</p> <p>A section within the incident report titled, Other Info, reflected the following, Resident was being transported to a room after a shower. Resident states he adjusted himself in chair and although he was not completely settled, he told CNA he was ready to go back to his room. Resident and staff educated on importance of sitting properly in chair prior to transporting.</p> <p>Review of Resident #51's discharge placement sheet from hospital dated, 01/18/25 reflected,</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #51 presents with a right distal shaft femur fracture after falling out of the shower chair at the nursing home today. He said while sitting on the chair the wheels broke down and he fell to the ground with his knee bent underneath him. Injury occurred at [name] Nursing home. He reported experiencing immediate pain, gross deformity, and inability to bear weight about his right distal thigh after the accident. Patient was initially taken to the [name] ER where x-rays were obtained and then a decision was made to transfer the patient by ambulance to the hospital for further evaluation and care. Preliminary x-rays were obtained revealing the above-mentioned fracture(s)/injury(s) and Orthopedic surgery was consulted.</p> <p>It is also noted, (Resident #51) says fall was mechanical when was accidentally pushed out of wheelchair.</p> <p>Review of facility's record in TULIP reflected the incident was not reported to the State Agency. A complaint was filed by Resident #51 alleging neglect due to his fracture on 03/28/25. This complaint was investigated and found to be unsubstantiated.</p> <p>During an interview on 04/14/25 03:47 PM Resident #51 stated that he fell out of the shower chair in January of 2025. He stated he was in the hospital for 3 days and came back to receive physical therapy that had been working. He stated the wheels were not properly functioning, and he tipped forward with his leg underneath him. He did have a pending litigation with the facility. If the facility had been more responsive to what happened to him, he would not bring legal action against the facility.</p> <p>During an interview with the Corp N. on 04/16/25 10:28 AM revealed they did not report the incident to the State Agency. They did an in-house investigation to rule out neglect. She mentioned she investigated the incident in the event that there was pending legal action, which there was none. She stated the fall was witnessed so they did not say abuse. They ruled out neglect earlier and major bodily injury was not sign of neglect according to her policies. She stated they checked the wheelchairs and did an in-service to retrain everyone.</p> <p>During an interview with LVN A on 04/16/25 at 12:45 pm, she was a witness to the incident, and she did not suspect abuse or neglect. She stated the wheel of the chair just gave out. She thought any fracture should be reported to the state. She had received many in-services on abuse and neglect and knew the ADM was the abuse and neglect coordinator. She noted that if she had known it was not reported to the State she would have reported it.</p> <p>During an interview with DON on 04/16/25 at 2:30 pm she said that the abuse and neglect coordinator was the ADM. She stated she does not know Texas law for reportable yet. She stated that any event needs to be reported if it's within the law. She stated the event with Resident #51 happened on her second day and she was not involved in the incident.</p> <p>(continued on next page)</p>		

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 05/05/2025
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.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with ADM on 04/16/25 at 3:01 pm revealed that she did not report to the stated because she believed the fall was witnessed and the facility had done their due diligence ruling out abuse and neglect within the two-hour period. They had checked that the weight limit was under his weight and verified that the aide had not done anything wrong. They were able to clear it in-house. According to her it was not suspicious. They did not report it within two hours of learning about the injury because they weren't aware it was a major injury until he arrived back at the facility. She stated that it was not up to the state to be the determining factor if an injury was considered neglect.</p> <p>Review of facility policy titled, Abuse Prohibition Policy, reviewed May 17, 2024.</p> <p>2. The facility will report all allegations and substantiated occurrences of abuse, neglect or misappropriation of resident property to the state agency and to all other agencies as required by law and will take all necessary corrective actions depending on the results of the investigation. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within two hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries.</p> <p>a.Initial Reporting</p> <p>i.Facility must provide sufficient information to describe the alleged violation and indicate how residents are being protected. Information should include, but is not limited to:</p> <ol style="list-style-type: none"> 1.Basic facility information 2.Allegation type 3.When the facility became aware of the incident 4.Information about the alleged victim and perpetrator 5.Witnesses 6.Details about the allegation, including outcomes to the alleged victim 7.Notifications that were made to law enforcement or other agencies 8.Steps taken immediately to ensure resident(s) are properly protected 9.Who is submitting the report 		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on observation, interviews, and record review the facility failed to provide, based on the preferences of each resident, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 5 of 5 confidential residents reviewed for activities.</p> <p>The facility failed to provide activities to meet the residents' interests on Saturdays and Sundays for 5 confidential residents.</p> <p>The facility failed to provide activities to support the mental and physical wellbeing of the residents in the secured unit.</p> <p>These failures could place residents at risk for decline in quality of life, social and mental psychosocial wellbeing.</p> <p>Findings Include:</p> <p>Observation on 04/14/25 at 10:30 am in the hallways of the secured unit revealed 3 residents in the hallway walking in and out of open rooms. The ACT was conducting an activity with two residents and was walking in and out of the doorway watching the 3 wandering residents.</p> <p>Observation on 04/14/25 at 2:30 pm in the main room of the secured unit revealed the ACT was the only staff member visible for 15 minutes while LVN E and CNA D were attending to residents. Resident's were sitting at the table. 2 residents were holding babies. There was no formal activities being done.</p> <p>Observation on 04/15/25 at 10:30 am the ACT was doing an activity with eggs with 4 resident's at a table. 5 Residents were watching TV. 3 residents were at another table that the ACT had to walk away from her egg activity 3 times in order to deescalate a situation between residents where there was no nursing staff available to intervene.</p> <p>In a confidential interview on 04/14/25 at 11:33 am the person revealed they did not see why people would not be bored. There were very few staff members there and nothing to do that they wanted to do.</p> <p>During a confidential group interview on 04/15/25 at 02:04 p.m., 5 confidential residents, stated there are no weekend activities. They stated it was boring and that all they did was smoke and grab games from the activities director office.</p> <p>Interview with CNA D on 04/15/25 at 2:30 pm, he stated he felt the residents needed more to do because the was only there from 10 am - 4 pm. CNA D stated he turned on the TV for them and would play music they like to fill the hours in between activities so the residents do not become bored and agitated. He states it was hard for ACT to get all the activities done because she's trying to get people to participate who walk away . He stated she can't bring people outside because most of the time there's not enough staff to safely watch the individuals left inside.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with LVN E on 04/15/25 at 3:30 pm, she stated she normally worked 2-10 and when activities are over and it was her responsibility to figure out what to do for them. The residents were bored of watching TV or coloring when she arrived for her shift. She wished she had more support for activities later into the day.</p> <p>Interview with PA on 04/15/25 at 7:20 pm she revealed the residents in the memory care are under-stimulated and they need something simple like an educational DVD. She noted, they primarily hang out in the lobby. She knew the residents were bored and looked for something to do when they wander.</p> <p>Interview with LVN F on 04/15/25 at 10:37 am she stated that on the weekends when she worked they did not have activities. She was unable to provide activities for the residents other than grabbing baby dolls or colors because she was busy providing oversight for all the residents. She stated they do not have volunteers come on the weekends and all that was available is colors, puzzles, and baby dolls. She stated it made her sad because she knew the residents want to do more. She stated that when they have an activities person come on the weekends it made a big difference for the residents.</p> <p>Interview with Resident #50's RP 04/15/25 at 1:30 pm she stated Resident # 50 was very social, but was struggling to interact appropriately and it will get her in trouble. She stated that she would have liked someone there to consistently guide Resident #50 in an appropriate way .</p> <p>Interview with ACT H 04/15/25 at 2:45 pm, she stated that her mother is in the locked unit where she works. She stated she has worked at the facility for over a year as an activities assistant. She stated they have a travel club every month and do activities related to the destination of the travel club. She stated it was hard to keep all the residents engaged. She stated they have a new activities aide that worked 9am -4 pm. She planned a few activities, helped the residents prepare for lunch, pass out lunch, and then do a few more activities. She noted it was difficult to get the entire job done between 9 am and 4 pm because there were many interruptions and the residents do not transition well.</p> <p>Interview with ACT 04/16/25 at 9:45 am she stated that she works back there daily, and she did her best to complete the activities, but she was called on frequently to help residents who were wandering or exhibiting inappropriate behaviors. She stated she gets interrupted very often to deal with behavioral issues. She stated it's decreasing their engagement because they are constantly interrupted with residents with behavioral issues. She noted, they needed to be engaged all day until bedtime, but sometimes they just watch TV all evening.</p> <p>Interview with MA G 04/16/25 at 11:33 am she stated that they did mostly coloring activities with the residents. She stated they did not sit on the patio and they did not do any physical activity related activities.</p> <p>Interview with DON 04/16/25 02:30 PM she stated that the ACT was only part time. She expected the ACT to only focus on activities as that was her job title. She was unsure if a part-time roll was adequate for the secured unit. She expected the staff to be creative in finding things to do. She stated that they are working on a different approach to manage behaviors and would start working on non-pharmacological interventions for their dementia patients.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with ADM 04/16/25 03:01 PM she stated the activities aide was a supplement to other nursing staff for supervision. The ADM stated the ACT's position was a part of the enrichment. She stated they tried to adjust activities based on the resident's needs. The schedule was supposed to be flexible. She stated she would ideally like the ACT to work full-time, but the budget did not allow it. They had to rely on the aides that are there on the weekend to fulfill her activities roll. She stated they did the best they can given the budget constraints.</p> <p>Record Review of the Activities Calendar for April of 2025 for the 600-hallway secured unit revealed that:</p> <p>Sunday's residents are offered a Word Search Packet, Lifeworks Daily and Refreshment and Coloring and Music in the afternoon.</p> <p>Saturday's residents are offered a crossword packet, Balloon Toss and movie and refreshments and matching games.</p> <p>Activities on April 14th included a bunny dice game at 10 am, egg matching at 10:30 am, a trip outside at 1:30 and matching games at 2 PM.</p> <p>Activities on April 15th included Perfect Pair at 10 am, Balloon Toss at 10:30 am , painting at 1:30, and discussions at 2 PM</p> <p>Activities on April 16th included Bunny Racing at 10 am, making music at 10:30 am, movement at 1:30 and coloring at 2 PM</p> <p>During a review of Facility's policy Activity Programs dated 2001 stated</p> <ol style="list-style-type: none"> 1. <p>Our activity program is designed to encourage restoration to self-care and maintenance of normal activity which is geared to the individual resident's needs.</p> <ol style="list-style-type: none"> 3. <p>Our activity program consists of individual, and small and large group activities which are designed to meet the needs and interests of each resident and includes, as a minimum:</p> <ol style="list-style-type: none"> a. <p>Social activities;</p> <ol style="list-style-type: none"> b. <p>Indoor and outdoor activities;</p> <ol style="list-style-type: none"> c. <p>Activities away from the facility;</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. Religious programs;</p> <p>e. Creative activities;</p> <p>f. Intellectual and educational activities;</p> <p>g. Exercise activities;</p> <p>h. Individualized activities;</p> <p>i. In-room activities;</p> <p>j. Community activities.</p> <p>6. Individualized and group activities are provided that-</p> <p>a. Reflect the schedules, choices and rights of the residents;</p> <p>b. Are offered at hours convenient to the residents, including evenings, holidays and weekends;</p> <p>c. Reflect the cultural and religious interests of the residents; and</p> <p>d. Appeal to both men and women as well as all age groups of residents residing in the facility.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure residents had adequate supervision and assistance devices to prevent accidents for 1 (resident #51) of 10 residents reviewed for accidents and hazards.</p> <p>The facility failed to provide safe transport for Resident #51 on 01/17/25 that resulted in a fall and fracture to the right femur.</p> <p>This has led to anxiety around shower times, and a reduced quality of life.</p> <p>An IJ was identified on 05/02/2025 at 4:30 PM. The initial IJ template was provided to the facility on [DATE] at 4:38 PM. While the IJ was removed on 05/04/25 at 12:21 pm, the facility remained out of compliance at the scope of isolated and a severity of no actual harm due to the injury sustained by Resident #51.</p> <p>Findings Included:</p> <p>Record review of Resident #51's face sheet dated 04/16/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included unspecified fracture of the right femur, chronic obstructive pulmonary disease(a disease that makes it hard to breath and causes lung deterioration, morbid obesity, fall from non-moving wheelchair, and osteoarthritis (arthritis of the bones which causes widespread generalized pain.)</p> <p>Record review of Resident #51's care plan revised 02/12/25 reflected Resident #51 has impaired visual function related to legal blindness, had a right femur and right tibia fracture related to fall with interventions to initiate PT, OT, and pain treatment as indicated by MD.</p> <p>Record Review of Resident #51's MDS dated [DATE] indicated a BIMS score of 15 indicating intact cognition, a mood interview score of 5, and extensive assistance for bed mobility, transfers, and toilet use. He required two person assist for transfers between surfaces; MDS states this excludes to/from bath and toilet. Resident #51 had received 150 minutes of physical therapy starting on 01/22/25 and ended 02/28/25.</p> <p>Review of Resident #51's incident report dated 01/17/2025 at 11:12 am reflected the following, This nurse seen when resident fell out of the shower chair while shower aid was bringing him back to his room from just receiving a shower. EMS has been called and are here at the facility as the resident states he thinks he broke his right knee. (Family) has been contacted a few times without success will attempt to contact later. MD aware. Incident and vitals initiated at this time. Resident stated, I think I heard a loud pop. I think I broke my right knee.</p> <p>A section within the incident report titled, Other Info, reflected the following, Resident was being transported to a room after a shower. Resident states he adjusted himself in chair and although he was not completely settled, he told CNA he was ready to go back to his room. Resident and staff educated on importance of sitting properly in chair prior to transporting.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #51's discharge placement sheet from hospital dated, 01/18/25 reflected, Resident #51 is a [AGE] year old right-hand dominant male with a past medical history reported by the patient to have morbid obesity, CHF, Afib, congenital hydrocephalus (blindness), HTN, OSA who presents with a right distal shaft femur fracture after falling out of the shower chair at the nursing home today. He said that the while sitting on the chair the wheels broke down and he fell to the ground with his knee bent underneath him. Injury occurred at (name) nursing home. He reports experiencing immediate pain, gross deformity, and inability to bear weight about his right distal thigh after the accident. Patient was initially taken to the (name) emergency room where x-rays were obtained and then a decision was made to transfer the patient by ambulance to hospital for further evaluation and care. Preliminary x-rays were obtained revealing the above-mentioned fracture(s)/injury(s) and Orthopedic surgery was consulted. It stated Resident #51's weight was 575 lbs.</p> <p>During an interview on 04/14/25 03:47 PM, Resident #51 stated that he fell out of the shower chair in January of 2025. He stated he was in the hospital for 3 days and came back to receive physical therapy that had been working. The accident occurred after his shower while he was still wet. The wheels were crooked the CNA they rounded a corner and the CNA to pushed him forward, his leg got caught underneath his body. When he fell, and he heard a pow. He stated he was embarrassed because his covering came off, he was naked on the floor. The staff ended up covering him up. He did have a pending litigation with the facility. He believed they are using the same shower chair, and it causes his anxiety around shower time. He stated he only trusts one specific CNA to shower him because the CNA is strong enough to handle him. He did have a pending litigation with the facility. If the facility had been more apologetic to what happened to him, he would not bring legal action against the facility.</p> <p>During an interview with the Corp N. on 04/16/25 10:28 AM revealed they completed an in-house investigation to rule out neglect. She stated they checked the wheelchairs and did an in-service to retrain everyone. She stated the fall was witnessed so they ruled out abuse. They ruled out neglect earlier and major bodily injury was not sign of neglect according to her policies.</p> <p>During an interview with LVN A on 04/16/25 at 12:12 pm, she was a witness to the incident, and she did not suspect abuse or neglect. She stated the wheel of the chair just gave out and he slid forward onto the floor out of the chair. She saw his leg get twisted underneath him and was apart of the team that helped him get situated correctly. She stated she knew the wheelchair was ok for him and normally had one person wheeling him. She stated she thought maybe in that situation he should have been wheeled backwards, but was unsure of anything that could have been done differently to prevent the situation.</p> <p>During an interview with DON on 04/16/25 at 2:30 pm. She stated the event with Resident #51 happened on her second day and she was not involved in the incident. She did not have any further comments about the accident.</p> <p>During an interview with ADM on 04/16/25 at 3:01 pm revealed that she did not report to the stated because she believed the fall was witnessed and the facility had done their due diligence ruling out abuse and neglect within the two-hour period. They had checked that the weight limit was under his weight and verified that the aide had not done anything wrong. They were able to clear it in-house. According to her it was not suspicious.</p> <p>The investigation was reopened on 05/02/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation of the shower chair as identified by the resident on 05/2/25 at 10:15 am revealed it was properly working and had a weight limit of 600 lbs.</p> <p>Interview with CNA on 05/02/25 at 10:21 am revealed that she had showered him three times before. She was sure that the shower chair's weight was certified for him. She stated she was confident the wheelchair was working because she looked at it and pushed it from the shower room to his room to transfer him. She stated when they went around the corner the wheel got stuck and I pushed him at a different angle. When I pushed the chair forward it tipped forward and was unable to catch him. He had fell on his right leg. She waited with him until EMS arrived.</p> <p>Interview with MAINT on 05/02/25 at 11:09 am, stated that he is up to date on most of the maintenance and he had looked at the shower chairs that month and saw nothing unusual. He stated he looked at the chair after the fall and saw no issues with the chair. He stated he didn't know if they had replaced the shower chairs.</p> <p>Interview with RP from the manufacturing company on 05/2/25 at 11:56 am said the shower chairs were able to be used for transportation.</p> <p>Record review on 05/02/2025 at 12:30 pm revealed shower chair maintenance had been completed January 7, 2025.</p> <p>Record review of shower chair's owner's manual states, Always abide by weight capacity. Never allow the user to suddenly shift weight in any way creating a tipping hazard for the user and the equipment. Equipment may not be appropriate for all individuals. Assessment should be conducted by a skilled caregiver for proper suitability for the individual using the equipment.</p> <p>Record review of facility policy titled, Policy for Resident Incident and Visitor Accident Reports dated 07/23/18 stated,</p> <p>The facility will conduct an investigation of all incidents involving residents of the facility.</p> <p>Incidents/Accidents of Unknown Origin will be reported in accordance with state and federal regulations.</p> <p>Any employee witnessing or having knowledge of an incident or accident involving a resident or visitor must immediately report such occurrence to his/her supervisor. The supervisor and/or employee must immediately notify the charge nurse to ensure proper medical attention can be provided.</p> <p>Regardless of how minor an incident/accident appears to be, it must be reported to the Department Supervisor, Administrator, or DON /designee.</p> <p>As soon as possible after becoming aware of an incident/accident, the Witness Form must be completed by any person witnessing the incident or any person thought to have witnessed the incident.</p> <p>An Incident Report must be completed by the person reporting the incident or the supervisor on the shift that the incident occurred.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Investigation must be initiated by the Department Supervisor or Charge Nurse and completed by the Administrator or DON/designee.</p> <p>Record review of facility policy titled, Abuse Prohibition Policy, reviewed May 17, 2024.</p> <p>2. The facility will report all allegations and substantiated occurrences of abuse, neglect or misappropriation of resident property to the state agency and to all other agencies as required by law and will take all necessary corrective actions depending on the results of the investigation. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within two hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries.</p> <p>a.Initial Reporting</p> <p>i.Facility must provide sufficient information to describe the alleged violation and indicate how residents are being protected. Information should include, but is not limited to:</p> <ol style="list-style-type: none"> 1.Basic facility information 2.Allegation type 3.When the facility became aware of the incident 4.Information about the alleged victim and perpetrator 5.Witnesses 6.Details about the allegation, including outcomes to the alleged victim 7.Notifications that were made to law enforcement or other agencies 8.Steps taken immediately to ensure resident(s) are properly protected 9.Who is submitting the report <p>An IJ was identified due to the above findings on 05/02/25 at 4:30 PM</p> <p>The POR was as follows:</p> <p>On 5/2/2025 an abbreviated survey was initiated at Nursing Facility. On 5/2/2025 the surveyor an immediate jeopardy (IJ) Template notification that the regulatory Services has determined that the condition of the facility constitutes an immediate threat to resident health and safety.</p> <p>The notification of Immediate Jeopardy states as follows: The facility failed to provide safe transport for Resident #51 on 01/17/25 that resulted in a fall from his shower chair and fracture to the right femur.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Action:</p> <p>Resident #51 was assessed on 5/2/2025 for safety during bathing, including the use of the bariatric shower chair which was confirmed for continue use by DON. Other options were explored to include bed bath per resident preference and caregiver preference per resident preference. If assistance is needed, staff knowledgeable on how to stop and ask for support during transport. As changes arise, care plan and Kardex will continue to be modified and staff will receive education tailored to mobility needs of individual residents.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: 5/2/2025</p> <p>Responsible: DON</p> <p>Action:</p> <p>Audit completed with other residents, no other residents identified to be using the bariatric shower chair. As is standard protocol and nursing procedures, unless a resident is self-ambulatory, a resident is transported in a shower chair or gurney. Resident #51 was noted to be the only resident utilizing the bariatric shower chair. Also, during transport, caregivers will continuously remind resident of safety awareness such as placement of feet, arms, etc. to mitigate accidents during transport.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: 5/2/2025</p> <p>Responsible: DON</p> <p>Action:</p> <p>Corporate Clinical Nurse in-serviced ADM, DON, Maintenance Director, and ADON on accidents and hazards to include safe transport practices (intact, free of debris, functionality) including navigating shower chairs and responding to concerns. Verbal quiz was given to ensure competency.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: 5/2/2025</p> <p>Responsible: Corporate Clinical Nurse</p> <p>Action:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All nursing staff in-serviced on accidents and hazards to include safe transport practices, including navigating shower chairs and responding to concerns, process if issue is identified, who to report to, and when to report. Verbal quiz was given to ensure competency. If resident is noted to shift weight or become unstable during transport, then staff is trained to stop transport and request assistance.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: 5/2/2025</p> <p>Responsible: DON/Designee</p> <p>Action:</p> <p>All training material will be incorporated into the new hire orientation. The training material to be included for all current nursing staff, new hires, PRN, and agency to show they were in-serviced on accidents and hazards to include safe transport practices, including navigating shower chairs and responding to concerns, process if issue is identified, who to report to, and when to report. If resident is noted to shift weight or become unstable during transport, then staff is trained to stop transport and request assistance. No employee will be allowed to work without completion of this training. Competency will be validated by verbal quizzing which will be recorded in an in-service and a copy placed in their employee file.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: 5/2/2025</p> <p>Responsible: Administrator</p> <p>Action:</p> <p>Maintenance director in serviced by Regional Nurse on proper navigation and handling of shower chairs, accidents and hazards to include safe transport practices (intact, free of debris, functionality) including navigating shower chairs and responding to concerns. Maintenance Director conducted full audit of all shower chairs on 5/2/25 to ensure safety and integrity. No negative findings noted. Maintenance director will continue to monitor and audit shower chairs through TELS monthly tasks. Any issues to be reported to Administrator and Director of Nursing/designee and shower chair to be taken out of service until issue is resolved. Any issues and their coordinating resolution to be documented in TELS work orders.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: 5/2/2025</p> <p>Responsible: Maintenance Director</p> <p>Action:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>DON/designee will observe shower completion and transportation 3x a week x 4 weeks to validate compliance and safety. Findings will be documented on audit tool. DON/designee looking to identify appropriate transport device and validate the plan of care per individual resident and staff transports are conducted appropriately.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: ongoing</p> <p>Responsible: DON</p> <p>Action:</p> <p>The DON/designee will review incident reports weekly to detect trends, intervene promptly, complete root cause analysis, implement interventions, and present findings to the QA Committee for review and necessary revisions.</p> <p>Start Date: 5/2/2025</p> <p>Completion Date: ongoing</p> <p>Responsible: DON</p> <p>THE POR WAS MONITORED AS FOLLOWS:</p> <p>Initial facility walk-thru on 05/03/2025 at 11:00 am revealed 7 residents up in wheelchairs to be sitting in common area next to nurse station watching television. All residents appeared neatly groomed. Further observation revealed 2 residents in wheelchairs near medication cart. One resident having vitals taken by RN A second resident receiving medications from MA G . CNA I sitting outside of room [ROOM NUMBER] for resident providing one to one sitting. CNA I stated she has provided one-to-one yesterday and today. Observation of resident coming down 200 hall walking with rolling walker to common area to watch television. Observation of housekeeping staff on 300 hall cleaning rooms.</p> <p>Record review of in-service of Safe Transport Practices-Shower Chair Safety and Response on 05/03/25 revealed 37 staff members have documentation of receiving in-service.</p> <p>In an interview on 5/3/25 at 2:41 PM with CNA J revealed CNA J stated she has received ANE in-service recently. CNA J states ANE is reported to the charge nurse and the ADM. CNA stated any suspicion of ANE is to be reported. CNA J stated if a resident falls either witnessed or unwitnessed then that is also to be reported to the charge nurse and the ADM. CNA J stated she recently received an in-service on safe transporting with the shower chairs. CNA J stated the shower chair needs to be inspected prior to use by the staff member and if the chair does not roll properly or is any form of disrepair then it should not be used and it should be reported to the charge nurse and maintenance. CNA J states if a resident shifts or slides while in shower chair then the staff member should get help from another staff member to readjust resident before continuing transport.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/3/25 at 3:00 PM with CNA I revealed CNA I stated she had recently received an in-service about abuse neglect and exploitation and who to report to. CAN I stated any concerns would be reported to the ADM. CNA I stated all falls are reported to the charge nurse and the ADM. CNA I stated she had received an in-service about safe transport with the shower chairs. CNA I states the shower chairs are to be inspected for safety before using with a resident. CNA I states if the shower chair is unsafe then it is to be reported to the charge nurse and the ADM. CNA I stated she thinks there is a book where it is documented and reported to maintenance, but she is not positive as she has never had to complete a work order or document on any unsafe equipment. CNA I stated if she had a resident in a shower chair and they started to slide out or readjusted and became unstable she would stop and try to secure the resident and call out for assistance from another staff member if needed.</p> <p>Observation on 05/04/25 at 11:13 am revealed no foul smells, the building was clean, residents in were in TV area watching TV, all residents interviewed for safety in showers chairs had call lights close to them.</p> <p>During interviews on 05/04/25 from 11:30 am - 5:15 pm 2 RNs, 8 LPN/LVN, and 20 CNAs from different shifts all stated they were in-serviced before working their shift. Their in-service included assessing shower chairs for safety before they were used, what to do if a resident shifts their weight, reporting unsafe shower chairs, and abuse and neglect.</p> <p>Interview with Corp N. on 05/04/25 at 2:30 pm she stated that she in-serviced the ADM, DON, ADON, MAINT on shower chairs and equipment, reminding residents of their safety, who to report shower chairs to and how to take it out of service and replace it.</p> <p>Interview with MAINT on 05/04/25 at 2:41 pm, he stated he was in-serviced by the Corp. N. about abuse and neglect, auditing the shower chairs, reviewed shower chair safety, and how to remove unworking shower chairs from service.</p> <p>Interview with ADON on 05/04/25 at 2:55 pm, she state that she was in serviced on abuse and neglect, safe transport in the shower chair, how to assess shower chairs for safety and how to assess resident safety in the shower chairs.</p> <p>Interview with DON on 05/04/25 at 3:05 pm revealed she was in-serviced on abuse and neglect, shower chair safety, inspections of shower chairs, reporting broken equipment to ADM and how to take broken shower chairs out of service.</p> <p>Record review of Shower Chair Inspection Audit document on 05/04/25 completed by MAINT revealed Shower chairs were audited on 02/02/25 and passed the audit.</p> <p>Record review of Staff In-service training record on 05/03/25 revealed that ADM, ADON, DON, and MAINT were in serviced by Corp. N on safe transport practices on 05/02/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of progress notes dated 05/03/25 at 12:55 am stated, Resident transferred to bariatric shower chair via lift and assist of 2 staff for purpose of assessing the resident' seated balance and positioning outside the scheduled shower time. Resident remained seated in chair without difficulty. Resident did not display any signs of leaning, instability, or distress during this assessment. No concerns identified at this time. Finding are consistent with safe use of current equipment and staff assistance.</p> <p>Record review of statement submitted on 05/04/25 stated, this is a written statement verifying that [Resident #51] is the only resident who currently uses the bariatric shower chair at [Facility name] in [City, State] as of this date.</p> <p>Record review of New Hire Orientation paperwork packet on 05/04/25 revealed safe transport practices for shower chairs were a part of the education and orientation.</p> <p>Record review of statement provided on 05/04/25 revealed an AD HOC QAPI plan meeting took place on 05/02/25 that included ADM, DON, ADON, and Medical Director.</p> <p>The ADM was informed the IJ was removed on 05/04/25 at 12:12 PM. The facility remained out of compliance at a scope of isolated and a severity level of no actual harm that was not immediate threat, due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review, the facility failed to have sufficient staff who provide direct services to residents to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for 14/14 residents that reside in the secured unit.</p> <p>The facility failed to adequately staff the secured memory care unit (600 hallway) which resulted in a disproportionate number of incidents affecting the 600 hallway.</p> <p>This failure could place residents at risk for accidents with major injuries, boredom, depression, and a decreased quality of life.</p> <p>Findings include:</p> <p>Resident #60</p> <p>Record review of Resident #60's face sheet dated April 15, 2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's Disease with late onset (a late onset of brain degeneration that include cognitive and memory functions), Dementia, and unspecified lack of coordination.</p> <p>Record review of Resident #60's Quarterly MDS dated [DATE] indicated a BIMS score of 04 indicting severe cognitive impairment, and supervision for bed mobility, transferring, eating, and toileting.</p> <p>Record review of Resident #60's Care Plan, last revised on 02/21/2025 stated, resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's Disease with late onset interventions include cue reorient, and supervise as needed.</p> <p>Resident #50</p> <p>Record review of Resident #50's face sheet dated April 15, 2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's Disease with late onset (a late onset of brain degeneration that include cognitive and memory functions), anxiety disorder, and major depressive disorder.</p> <p>Record review of Resident #50's Quarterly MDS dated [DATE] indicated a BIMS score of 99 indicting severe cognitive impairment. MDS indicated wandering activity happened 1-3 days a week, and resident needed limited assistance for bed mobility, transferring, eating, and toileting.</p> <p>Record review of Resident #50's Care Plan, last revised on 02/21/2025 stated she was evaluated as a wandering risk related to decreased safety awareness, confusion, and wandering behaviors. Interventions included checking location frequently, encouragement to participate in activities, observation for agitation, pacing, restlessness and to report behaviors for increased interventions.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/14/25 at 10:30 am in the hallways of the secured unit revealed 3 residents in the hallway walking in and out of open rooms. The ACT was conducting an activity with two residents. CNA D was in the shower room with a resident and the LVN E was not in sight.</p> <p>Observation on 04/14/25 at 2:30 pm in the main room of the secured unit revealed the ACT was the only staff member visible for 15 minutes while LVN E and CNA D were attending to residents.</p> <p>Observation on 04/15/25 at 9:30 am in the secured unit hallway revealed while interviewing LVN E, 2 residents in wheelchairs were being pushed by two ambulatory residents. A moment later the light in the shower room of the secured unit came on and the resident inside started screaming. CNA D stuck his head out to call for help. The nurse walked by the two ambulatory residents while on her way to the shower room and instructed them to stop pushing the wheelchair. She then continued walking. The ambulatory residents did not stop pushing the wheelchairs. The nurse then went into the bathroom and closed the door. There were no other staff members in the unit available for assistance.</p> <p>Observation on 04/15/25 at 10:30 am the ACT was doing an activity with eggs with 4 residents at a table. 5 Residents were watching TV. 3 residents were at another table that the ACT had to walk away from her egg activity 3 times in order to deescalate a situation between residents where there was no nursing staff available to intervene.</p> <p>Observation on 04/16/25 at 3:36 pm, while interviewing LVN E, 10 residents were eating a snack while watching TV. The room was crowded and loud with residual noise of resident's eating, moving around or coughing. A resident walked out of the room crying and began to knock on the locked exit doors for 10 minutes. At the same time, two other residents were fighting over their snack. There was no other staff member in sight to assist with the residents.</p> <p>Interview with Resident #60 was unsuccessful due to her cognitive impairments.</p> <p>In a confidential interview on 04/14/25 the person revealed they did not see why people would not be bored. There were very few staff members there and nothing to do that they wanted to do.</p> <p>Interview with CNA D on 04/15/25 at 2:30 pm, he stated he felt the residents are unsafe in the locked unit because they all have severe memory impairment and need constant supervision. To him, it was impossible to provide them with the necessary supervision while only two people are working back there. He felt like incidents and accidents happened disproportionately to his residents in the secured unit compared to the main community. He had communicated his opinions with the ADON with no response. He stated the resident's wandering tendencies are harder to control and they take things from other people's rooms. He stated that many falls happened when he was busy helping another resident. He stated he felt like he's always tied up caring for other residents and cannot provide them the oversight they need. He has been trained on dementia specific trainings multiple times a year, but it did not help him because they needed more physical presence.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with LVN E on 04/15/25 at 3:30 pm, she stated she had been trained on dementia behaviors. She had been working at the facility since January of 2025. She stated there was inadequate support when incidents happen. She would call for help and no one would come. She stated it was impossible for two people to keep an eye on the residents. If the CNA called her into the shower for a skin issue it would be inevitable that when she walked out something would happen. She stated it was a lack of CNA presence that was an issue, but another nurse would be nice. She stated they needed assistance with ADL's and supervision.</p> <p>Interview with PA on 04/15/25 at 7:20 pm she revealed that she has been the Psychiatric Physician's Assistant at the facility for over a year. She said They do not have enough staff to get it done. The staffing is so short handed that if the residents want to fall asleep on the couch they would just leave them. I don't know if and how they are making it happen. She wondered what happened when no one was watching because it happened often. She noted the lack of urgency with some of the nurses because she believed they were burned out.</p> <p>Interview with LVN F on 04/15/25 at 10:37 am she stated it was very hard to get all the work done with only two sets of eyes on the residents. She stated they would absolutely benefit from a second aide being back there. She stated on the overnight shifts there are just two aides and the nurse stayed outside the locked unit. She stated the resident's do not stay asleep throughout the night and it could get dangerous with just two aides in the locked unit. She reported to the bad days and agitated unit makes everyone in a bad day no matter how many people are back there .</p> <p>Interview with RP of Resident #50 on 04/15/25 at 1:30 pm she stated Resident #50 was being cared for in an O.K. manner. Resident #50 was very social, but was struggling to interact appropriately and it will get her in trouble. She stated she would have liked someone there to consistently guide her Resident #50 in an appropriate way.</p> <p>Interview with ACT H/ RP of Resident #60 on 04/15/25 at 2:45 pm, she stated Resident #60 was in the locked unit where she worked. She stated she worked at the facility for over a year. They have recently increased the number of residents to 14 and are full. She stated in October of 2024 they removed the second aide off the hall during the daytime because of low numbers. They had not increased the staff with the capacity increase. She stated there were more unexplainable falls and aggression incidents. The residents were wandering more into other's rooms. She stated the residents look for the bathroom, but no one was there to show them their room. She stated the residents fall often. There was one resident who had fallen 4 times in a week because she thought it was the lack of supervision. She stated the staff were so busy when she arrived in the morning, she would make Resident #60 bed and dress her. Her family member had the same experience on the weekends. She stated she had been trained on dementia specific behaviors.</p> <p>Interview with ACT 04/16/25 at 9:45 am she stated she worked in the secured unit daily, and she did her best to complete the activities, but she was called on frequently to help residents who were wandering or exhibiting inappropriate behaviors. She stated she got interrupted very often to deal with behavioral issues. She stated it was decreasing their engagement because they are constantly interrupted with residents with behavioral issues. She stated she had been trained on dementia specific behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with MA G 04/16/25 at 11:33 am she stated some days are better than others, but she felt like there was an uptick in the number of bad days over the last week. She stated when residents were having a bad day they should have had a floating staff member come back and assist for multiple hours. Floating staff members in the past had only assisted for less than an hour. She was concerned about the resident's wandering habits when staff were engaged in ADL provision. She stated she was nervous that they would have hurt themselves while unattended.</p> <p>Interview with LVN A on 04/16/25 at 12:45 pm, she stated they do not have enough people to staff the locked unit. She would substitute a few times weekly. She stated she would be giving medications to someone in their room and the CNA will be doing ADL's with someone and in that situation there was always someone exhibiting aggressive behaviors. She stated when I am back there, I don't have enough arms. I can not be in 14 places at the same time and the resident's genuinely need it.</p> <p>Interview with AD 04/16/25 at 2:04 pm, she stated her activity assistant had only been there a month, but she had to stop and help with basic care and supervision needs multiple times daily. She stated it concerned her that there were only two people staffed back there. They did not know where the residents were at all times. If they are not around they are wandering in the hallway or were taking things from other resident's rooms. She stated because of their level of impairment they need eyes on them always. It made her worry that bad things are happening because of the lack of supervision.</p> <p>Interview with DON 04/16/25 02:30 PM she stated if the secured unit staff need assistance that they will ask. Yesterday was the first day they had asked for an additional staff member for support. She stated the activities aide should be back there to support them, but should be able to focus on their job. The DON stated she does not want her staff to feel overwhelmed. She stated they make sure the quality of care was not decreased as they meet their minimum scheduling. She stated they make adjustment to staffing with their PRN staff members.</p> <p>Interview with ADM 04/16/25 03:01 PM she stated they have a nurse and a CNA staffed at all times. They should have at least two people at minimum back there. She stated the activities director was there and was available to help out as needed, but should focus on her job. She stated it was hard to say if there was a lack of staffing in the secured unit. She stated at the end of the day they are safe and that she was aware it can look like there was no staff back there. She had heard complaints from the staff that they are overwhelmed regularly, but they do not communicate to her while events get bad. She stated she believes the staffing shared a fair load.</p> <p>Record Review of Incident Logs on 04/14/25 revealed that 60 of 147 or 40% of the total incidents occurring since January 1, 2025 involved the 14 residents (22% of the total facility population) that resided in the secured unit of the 600 hallway.</p> <p>Physical Aggression Received Incidents: 3/4 residents resided in the 600 hallway.</p> <p>Exit Seeking Incidents: 3/4 residents resided in the 600 hallway.</p> <p>Bruise Incidents: 9/14 residents resided in the 600 hallway.</p> <p>Physical Aggression Initiated Incidents: 3/5 residents resided in the 600 hallway.</p> <p>Fall without Injury Incidents: 15/35 residents resided in the 600 hallway.</p> <p>(continued on next page)</p>		

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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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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Unwitnessed Fall Incidents 18/45 residents resided in the 600 hallway.</p> <p>Record Review of nursing staff logs indicates from 04/14/25-04/16/25 only one CNA for 14 residents was assigned for the overnight shift. There were only two nurses on staff overnight shift for the whole facility, 61 residents.</p> <p>Review of Policy Entitled Staffing, Sufficient and Competent Nursing dated 10/2022 stated,</p> <p>Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including:</p> <ul style="list-style-type: none"> a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental, and psychosocial well-being of each resident; c. assessing, evaluating, planning, and implementing resident care plans; and d. responding to resident needs. <p>Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 7 residents (Resident #116 and Resident #55) reviewed for infection control.</p> <p>The facility failed to ensure CNAs were conducting hand hygiene when changing gloves when providing peri-care to Resident #116</p> <p>The facility failed to ensure CNAs were following Enhanced Barrier Precautions by donning a gown with gloves when providing care to Resident #116 and Resident #55.</p> <p>The facility failed to ensure hand hygiene was being conducted with glove changes during Resident #116's wound care.</p> <p>These failures could place residents at risk of transmission of disease and infection.</p> <p>Findings included:</p> <p>Resident #116</p> <p>Record review of Resident #116's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included a pressure ulcer of sacral region at stage 4, diabetes mellitus type 2, pressure ulcer of the left heel, hypertension, and a history of falling.</p> <p>Record review of Resident #116's Quarterly MDS dated [DATE] reflected she had a BIMS Score of 15, indicating no cognitive impairment. The MDS further reflected Resident #116 needed the assistance of two or more helpers for her activities of daily living and used a mechanical lift with two people assisting for transfers, and a wheelchair for mobility. She had one unstageable deep tissue pressure injury to her sacrum.</p> <p>Record review of Resident #116's Care Plan, last revised on 04/14/25, reflected a focus on impairment to skin integrity described as wound to left superior sacrum. The goals were for Resident #116 to have no complications related to the sacrum through the review date. The interventions included providing incontinent care as needed, pressure ulcer/injury to show signs of healing as evidenced by a decrease in size/measurements, and to remain free from signs and symptoms of complications such as infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/15/25 at 10:31 AM of Foley catheter care for Resident #116 revealed signage on her door for Enhanced Barrier Precautions. CNA A and the ADON did not put on a gown before providing Foley catheter care for Resident #116. CNA A cleansed her peri-area with wipes and changed gloves without conducting hand hygiene prior to providing Foley catheter care. The ADON assisted in positioning Resident #116 on her side, and CNA A changed his gloves, but did not conduct hand hygiene before cleansing her bottom with wipes. A clear plastic trash bag was observed on and at the foot of bed that contained multiple wipes from cleansing a bowel movement, and a couple of the wipes were observed touching the resident's top sheet that was folded down. When CNA A removed his gloves after cleansing Resident #116's bottom, the ADON squirted some hand sanitizer into CNA A's hands and then CNA A donned clean gloves. Resident #116 was assisted/rolled to her right side to apply a clean brief, and her feet touched the soiled wipes that were in the clear plastic trash bag on the foot of the bed. Resident #116's black wound vac sponge was observed loose on her sacral area, and ADON removed the wound vac dressing so that wound care could be done. CNA A removed the soiled trash bag from the foot of the bed, and then pulled the contaminated sheet up over resident's waist for privacy.</p> <p>Observation on 04/15/25 10:54 AM of wound care for Resident #116 with LVN A and RN A revealed both of them donned a gown with gloves, per Enhanced Barrier Precautions signage on door. LVN A removed her gloves and conducted hand hygiene after cleansing Resident #116's sacral wound. LVN A did not put on gloves and picked up the black foam dressing with bare hands cut the black foam dressing to fit inside the sacral wound. LVN A then placed the black foam dressing on the clean field, sanitized her hands and donned gloves before proceeding with dressing the wound.</p> <p>Resident #55</p> <p>Review of Resident #55's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including colon cancer and neuromuscular dysfunction of the bladder,.</p> <p>Review of Resident #55's Quarterly MDS assessment, dated 02/08/25, reflected a BIMS Score of 14, which indicated mild cognitive impairment. The MDS further reflected Resident #44 needed the assistance of two or more helpers for her activities of daily living and used a mechanical lift with two people assisting for transfers, and a wheelchair for mobility.</p> <p>Observation on 04/15/25 at 11:32 AM of peri-care for Resident #55 with CNA A, and CNA B assisting. Signage was observed on Resident #55's door for Enhanced Barrier Precautions. Neither CNA A nor CNA B donned a gown before providing care. CNA B was observed providing hand sanitizer to CNA A while he was providing peri-care to Resident #55. CNA A was observed holding a glove in his right hand while haphazardly applying hand sanitizer to his hands, and then he put on the gloves.</p> <p>Interview on 04/15/25 at 11:46 AM with CNA A revealed he had worked as a CNA for 16 years. CNA A stated the facility did provide pocket hand sanitizer to the staff. CNA A further stated the ADON had been squirting hand sanitizer in his hand when he was providing care to Resident #116. CNA A further stated he had forgotten to put on a gown when providing care to Resident #116 and Resident #55, and a consequence could be passing infection on to another resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 04/16/25 at 09:55 AM with the ADON revealed she had worked at the facility since January 2025. The ADON stated the facility had hand sanitizer available for all the staff members to use when they were providing care. The ADON stated she had been giving CNA A hand sanitizer when this writer was observing Foley catheter care for Resident #116. The ADON stated all staff providing direct care to a resident that was on Enhanced Barrier Precautions should put on a gown with gloves. The ADON further stated a gown should be put on when doing wound care, foley catheter care, and peri-care. The ADON stated CNA A should have put on a gown when he provided care to Resident #116 and Resident #55.</p> <p>Interview on 04/16/25 at 09:55 AM with the DON revealed she had worked at the facility since January 2025. The DON stated the facility had hand sanitizer available for all the staff members to use when they were providing care. The DON stated all staff providing direct care to a resident that was on Enhanced Barrier Precautions should put on a gown with gloves. The DON further stated a gown should be put on when doing wound care, foley catheter care, and peri-care. The DON further stated CNA A should have put on a gown when he provided care to Resident #116 and Resident #55. The DON further stated the policy reflected all direct care staff should be washing their hands with soap and water when their hands are visibly soiled. Staff should perform hand hygiene before and after contact with the resident, after contact with blood, body fluids, or visibly contaminated surfaces, after contact with objects and surfaces in the resident's environment, and after removing personal protective equipment. Staff should also perform hand hygiene and put on clean gloves before performing a procedure such as an aseptic task of handling clean wound dressings.</p> <p>Record review of an In-service Record dated 11/01/24 for Infection Control/Enhanced Barrier Precautions/Contact Precautions reflected CNA A had signed the in-service.</p> <p>Record review of an In-service Record dated 01/16/25 for Enhanced Barrier Precautions reflected CNA A had signed the in-service.</p> <p>Review of Policy & Procedure on Handwashing/Hand Hygiene Residents 03/19/25 reflected:</p> <p>Policy Statement</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> Residents, family members and/or visitors will be encouraged to practice hand hygiene. Residents may be trained and encouraged on the importance of hand hygiene in preventing the transmission of infections. Handwashing posters will be displayed in various parts of the facility to serve as a reminder to residents regarding the importance of handwashing Hand hygiene products and supplies (sinks, soap, towels, alcohol -based hand rub, wipes etc.) shall be readily accessible and convenient for resident use to encourage compliance with hand hygiene policies. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. For residents who are unable to complete handwashing or require reminders, facility staff will provide assistance and encouragement as needed.</p> <p>A review of the CDC Long Term Care Facilities reflected when implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this:</p> <p>Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g. gown and gloves)</p> <p>For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves.</p> <p>Review of Enhanced Barrier Precautions, signage observed at the facility posted on the doors of other resident rooms, not posted on Residents #460 and #461's doors reflected:</p> <p>Enhanced Barrier Precautions:</p> <p>Providers and staff must:</p> <p>wear gloves and a gown for the following High-Contact Resident Care Activities. Do not wear the same gown and gloves for the care of more than one person.</p> <p>Providers and staff must also: Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheotomy Wound Care: any skin opening requiring a dressing.</p> <p>Review of facility Enhanced Barrier Precautions policy dated 03/19/25 reflected it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.</p> <p>Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs.</p> <p>Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities.</p> <p>EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient.</p> <p>EBP are indicated for residents with any of the following:</p> <p>o Colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply (see MDRO list on page 3); or</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>o Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid&reg;) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.</p> <p>Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheotomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP.</p> <p>The facility will ensure PPE and alcohol-based hand rub are readily accessible to staff prior to entry to their room.</p> <p>PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. For example, staff entering the resident's room to answer a call light, converse with a resident, or provide medications who do not engage in a high-contact resident care activity would likely not need to employ EBP while interacting with the resident.</p>