

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/24/2026
NAME OF PROVIDER OR SUPPLIER Lily Springs Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Central Texas Exp Lampasas, TX 76550	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on interview and record review, the facility failed to ensure residents had the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility for the residents through the means other than a postal service for 12 of 12 confidential residents reviewed for weekend mail delivery. The facility failed to ensure residents received their mail on the weekend, within 24 hours of delivery by the postal service. This failure could place residents at risk for not receiving mail in a timely manner that could result in a decline in residents' psychosocial well-being and quality of life. Findings included: During a confidential group interview on 06/23/26 at 09:38 AM, 12 of 12 residents stated mail was not distributed on Saturdays. They stated the mail delivered on Saturday did not get distributed until Monday or even picked up until Monday. The residents stated mail was distributed Monday through Friday only for what was delivered. During an interview on 06/24/26 at 01:19 PM with the AD, she confirmed that at one point there was no mail being distributed to residents on the weekends, however, recently there was a process change and that all of the leadership staff over every department was told that whomever the manager was on the weekend was responsible for distributing resident mail. She stated that mail was not being distributed on weekends because the BOM was concerned certain items belonging to her such as payments to the facility would go missing. The AD stated she believed mail was now being delivered/distributed on the weekends to residents by the department heads/ manager on duty. The AD stated it was a resident right to receive mail in the facility, including on weekends. She stated some residents relied on the weekend mail for activities such as books or other items they were expecting and if they didn't get it could lead them to become upset or disappointed. During an interview on 06/24/26 at 01:40 PM with the SW, she stated she was a department head and was a manager on duty on the weekend some times since all the department heads rotated. She stated she was recently the manager on duty at the beginning of the month in June 2026. She stated she did not deliver mail on the weekend; and further stated the manager on duty on the weekend would assist with meal trays, supervise meals and help the charge nurse in the halls with trays or dining room, would assist in rounds or answering call lights. The SW stated she was not assigned to mail delivery and did not know who was assigned to mail delivery on weekends. She stated weekend mail delivery as a resident right. She stated if she were a resident and she was not getting mail she would question why the mail was not being delivered. She stated the mailbox was not locked and any staff as able to get the mail and distribute It to residents. During an interview on 06/24/26 at 01:49 PM with the ADM, he stated it was the responsibility of the weekend manager on duty to deliver mail to the residents if any arrived on Saturday. He stated there was an in-service completed on 05/29/26 to all department heads training them on their duty to deliver mail on the weekend. He stated after reviewing the in-service, the SW had not been trained or signed off on the in-service for delivering mail. He stated weekend mail delivery was a resident right and he was not aware of it not being delivered. The ADM stated that if (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents were not getting mail on weekends, it had the potential to cause some grief or frustration. Review of a separate Nursing Facility Resident Rights policy dated 3/6/26 reflected:The following rights are guaranteed to residents of Texas nursing facilities under federal law and Texas law. Facilities are required to protect and promote these rights for every resident.To send and receive unopened mail.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation in that: The facility failed to ensure scoops for dry storage food bins were stored separately. The facility failed to ensure expired food items were removed from dry storage and discarded. The facility failed to ensure a box of sugar was sealed in a manner that prevented contamination. The facility failed to ensure 6 bags of tortillas were free of contamination which resulted in permanent marker used to date bleeding through into the food. The facility failed to ensure the DC washed his hands and changed his gloves during food preparation after touching contaminated surfaces. These failures could place residents who received prepared meals from the kitchen at risk for foodborne illness and cross-contamination. The findings included: During an initial tour on 06/22/26 beginning at 09:00 AM of the one and only kitchen revealed: 3 large, clear, plastic bins containing corn bread, sugar, and rice in the dry storage were observed with scoops/metal bowls left inside the bins with the food. A large white box of sweet potatoes with the receive date of 05/28/26 written in black marker was observed full of spoiled sweet potatoes that had sprouted and observed with large soft areas of spoilage/mold on them. 1 large box of sugar was observed open and exposed to room air. There was a bag in the box holding the sugar but was left open. There was sugar out of the bag (but still in the box) mixed with dark crumbs/unknown substance. 6 bags of flour tortillas were observed and ; the bags were clear/see through and labeled with black marker 6/4/26 which bled through the bag and onto the tortillas leaving them with large black smudge areas from marker. During a follow-up observation of the kitchen on 06/22/26 at 10:40 AM the DC was observed completing the preparation of the pureed food for lunch service, which included pork chops, beans, turnip greens, and bread. After each pureed item the DC was observed rinsing the blender, blade, and spatula in the 3-compartment sink before going and placing items on a tray and into the dishwasher. The DC would then grab the blender and move onto the next food item puree without washing his hands or changing his gloves after handling items in the 3-compartment sink (soiled dishes) and touching the dishwasher. After completing the last pureed food item, the bread, the DC was observed leaving the completed pureed food item at the workstation, cleaning the blender and blade in the 3 compartment sink before putting it into the dishwasher; then was observed handling a bucket of dirty sanitizer liquid that he disposed of in the 3 compartment sink, filling it with new sanitizer and wiping down the prep counter, and then returning to handling the pureed bread and covering it with plastic wrap all without washing his hands or changing gloves throughout the process of handling contaminated items. The DC was then observed taking food temperatures of all the food items on the steam table. After each item that he took the temperature of he would walk to the 3 compartment sink to rinse the probe before walking back to the steamtable to wipe the probe with an alcohol swab. He was observed dripping with water from the 3 compartment sink and each time failed to wash his hands or change gloves after working in the 3 compartment sink. During an interview on 06/22/26 at 09:21 AM with the DM, she stated that scoops were not supposed to be left inside the containers as it could result in contamination and they were supposed to be stored separately. She stated she personally checked the dry storage room weekly at minimum every Monday. She stated the last time she checked the potatoes they had not appeared moldy or spoiled. She stated she recently changed from regular to industrial sharpies and did not realize that they were bleeding into the food. She stated that the sugar that was left open should be closed to prevent contamination. She said (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	these failures had the potential to cause cross contamination of resident food. During an interview on 06/22/26 at 11:22 PM with the DC, he stated he did not change gloves or wash his hands during the pureed meal observation because he was not touching the food directly. He stated as long as he was not coming into contact with the actual food and only their containers there was no risk of cross contamination. During an interview on 06/22/26 at 11:25 PM with the DM, she stated it was her expectation that gloves were changed and hands were washed in between tasks. She stated that glove use or hand sanitizer was not a substitute for handwashing. She stated the DC should have changed his gloves and washed his hands after touching contaminated surfaces such as the 3-compartment sink or dishwasher before returning to food preparation. She stated a negative outcome of failing to wash hands or change gloves would be bacteria or allergens could spread and cross contamination with chemicals and resident food. During an interview on 06/22/26 at 11:32 PM with the RDN, she stated it was her expectation that expired food was removed and discarded. She stated that scoops should be kept separate and not left in the bins with dry food. She stated that hands should be washed and gloves were to be changed in between tasks. She stated wet hands should not be dripping into the food or on food items. The RDN stated that gloves were not a substitute for handwashing. She stated that she observed the DC not changing his gloves or washing his hands during food preparation while observed by surveyors. She stated a negative outcome of not washing hands or changing gloves would be infection control issues and cross contamination of resident food. During an interview on 06/24/26 at 01:49 PM with the ADM, he stated that scoops were not to be stored with the dry food in the bins. He stated that the expectation was they were to be in a bag or pocket beside the container for which it belonged. He stated it was for sanitation reasons and it was not standard for them to be stored in the container with food and he could not guarantee they had been sanitized if left in the container. The ADM stated that sugar arrived in a sealed bag and that it was the expectation that it was poured into a clean bin and covered. He stated that the DM was responsible for checking the dry storage area at least weekly and that all expired food was to be removed and disposed of. The ADM stated that sharpie can be used but if writing on clear plastic it was best to use a label they could write on to prevent it from bleeding into the food. The ADM stated that while doing food preparation the expectation was to sanitize/wash hands and glove up and staff should complete the task of making the food item and then proceed to clean the equipment. He stated wearing gloves was not a substitute for hand washing. He stated glove use and regular handwashing was used to prevent the spread of infection. He stated handwashing should occur before donning gloves and after disposing of gloves and anytime you see something on your hands. He stated if staff were in the process of doing temperature checks and working with food they needed to ensure their hands remained clean to prevent cross contamination. Review of the facility policy titled Food Receiving and Storage Policy last revised on 03/05/26 reflected: The facility will ensure that all food received, stored, and maintained in the facility is handled safely, protected from contamination, and maintained at appropriate temperatures to ensure food quality and resident safety. Food storage area, refrigerators, freezers, and dry storage rooms will be maintained in a sanitary condition and monitored to ensure compliance with safe food handling practices. Opened containers must be sealed or covered and dated. Expired foods must be immediately removed from storage. Foods stored in bins must be removed from original packaging and place in clean labeled bins or kept in the original packaging with proper labeling and dating. Opened foods must be tightly sealed and dated. Review of the facility policy titled Food Preparation- Dining Services last revised on 12/2020 reflected: Safe food handling and preparation shall be maintained to prevent food borne illness. Sanitation and safe food handling procedures shall be observed during meal preparation: Hands and surfaces shall be washed often. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Avoid cross contamination:Foods shall be prepared with the least possible manual contact, with suitable utensils, and on surfaces that have been cleaned, rinsed, and sanitized prior to use. Review of the facility policy titled Handwashing-Hand Hygiene Policy and Procedures last revised on 10/2020 reflected: This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine. Hand hygiene is recognized as the best practice for preventing healthcare associated infections. Applying and Removing Gloves:Perform hand hygiene before and after applying non-sterile gloves. Review of the 2022 U.S. Food and Drug Administration Food Code revealed:3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: P if(1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Of and(2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety.3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition.(A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it:(2) Is in a container or PACKAGE that does not bear a date or day; or3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation.FOOD shall be protected from cross contamination by:(4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish policies, in accordance with applicable federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents for 5 of (Resident #19, Resident #22, Resident #60, Resident #58 and Resident #07) of 7 residents reviewed for smoking. The facility failed to implement their smoking policy and conducted smoking evaluations as required per the policy for Residents #19, #22, #60, #58, and #07. The failure could place residents at risk of injury, burns and fire accidents from unsafe smoking practices. Findings included: Resident #19: Record review of Resident #19's face sheet dated 06/23/26 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of Alzheimer's disease, ulcerative blepharitis (acute inflammation of the eyelids) of right and left eyes, major depressive disorder, Huntington's disease (rare, inherited neurodegenerative disorder that causes the progressive breakdown of nerve cells in the brain), behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record Review of Resident #19's quarterly MDS dated [DATE] reflected BIMS of 03 which indicated that his cognition was severely impaired. Record review of Resident #19's care plan revised on 04/03/25 reflected that Resident #19 was at risk of injury due to his smoking preference. The relevant intervention was evaluating and monitoring safe smoke practices such as dexterity and coordination and evaluating his safe smoking ability. Record review of the smoking evaluations of Resident #19 revealed that the facility conducted a quarterly evaluation on 01/31/26. Resident #19's evaluation must be supervised while smoking as he had hand tremors and decreased finger dexterity due to Huntington's disease with history of accidents . During an observation on 06/23/26 at 1:10pm revealed Resident #19 was smoking outside in the smoking area. He was supervised by staff and needed moderate level of help in smoking the cigarette. The staff provided cigarettes and the smoking paraphernalia. An attempt to interview him was unsuccessful due to his cognitive capacity. Resident #22: Record review of Resident #22's face sheet dated 06/23/26 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of pain in unspecified joint, dementia, psychotic disturbance, mood disturbance, anxiety lack of coordination and muscle weakness. Record Review of Resident #22's quarterly MDS dated [DATE] reflected BIMS of 10 which indicated that his cognition was moderately impaired. Record review of Resident #22's care plan dated 09/09/25 reflected Resident #22 was at risk of injury due to his smoking preference. The relevant intervention was evaluating his safe smoking ability. Record review of the smoking evaluations of Resident #22 revealed that the facility conducted a quarterly evaluation on 09/09/25. The evaluation reflected that Resident #22 must be supervised while smoking as he had history of smoking in places that were not designated as a smoking area. He was unable to safely light and extinguish smoking materials. He had history of keeping cigarettes on him and in his room when coming back for outings, and when a friend brought them to him. There were no smoking evaluations performed on Resident #22 after 09/09/25. During an interview and observation on 06/23/26 at 1:10pm revealed Resident #22 was smoking outside in the smoking area. He was supervised by staff and needed a minimal level of help with smoking the cigarette. The staff provided cigarettes and the smoking paraphernalia. During the interview Resident #22 stated he loved smoking, however staff did not allow him to keep the cigarettes and lighter with him. He stated he was able to smoke unsupervised without any supervision and wished to keep cigarettes and lighter with him. Resident #60: Record review of Resident #60's face sheet dated 06/23/26 reflected a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with diagnoses of legal blindness, severe (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obesity due to excess calories, muscle weakness , difficulty in walking, lack of coordination and pain in unspecified joint.Record review of Resident #60's quarterly MDS dated [DATE] reflected BIMS of 14 which indicated his cognition was intact.Record review of Resident #60's care plan dated 10/17/24 reflected Resident #60 was at risk of injury due to his smoking preference. The relevant intervention was evaluating his safe smoking ability.Record review of the smoking evaluations of Resident #60 revealed that there was an annual evaluation conducted on 10/02/25 and confirmed that Resident #60 was a safe smoker. There was no smoking evaluations performed on Resident #60 after 10/02/25. During an interview and observation on 06/24/26 at 1:30pm revealed Resident #60 was smoking unsupervised outside in the smoking area with the company of Resident #58. He stated he was allowed to keep the cigarettes and lighter with him because he was a sensible smoker. He stated there were residents who did not know where and when to smoke. He stated smoking inside the facility or near oxygen supply was dangerous due to the fire hazard and he was particular to avoid such situations as well as vigilant about the compliance of other smokers. Resident #58:Record review of Resident #58's face sheet dated 06/23/26 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction (motor impairments that occur on one side of the body following a stroke) affecting left non-dominant side, pain in right hip, nicotine dependence, difficulty in walking and lack of coordination.Record review of Resident #58's quarterly MDS dated [DATE] reflected a BIMS of 15 which indicated that her cognition was intact.Record review of Resident #58's care plan dated 10/08/24 reflected Resident #58 was at risk of injury due to her smoking preference. The relevant intervention was evaluating her safe smoking ability.Record review of the smoking evaluations on 06/24/26 revealed that there was a quarterly evaluation conducted on 01/14/26 and confirmed that he was a safe smoker. There was no smoking evaluations performed on Resident #58 after 01/14/26. During an interview and observation on 06/24/26 at 1:30pm revealed Resident #58 was smoking unsupervised outside the facility in the smoking area with the company of Resident #60. She stated she and Resident #60 were allowed to keep the cigarettes and lighters with them and allowed to smoke independently. Resident #58 stated she was a responsible smoker and was cautious about the fire hazard and burn from cigarette. She stated she was vigilant about the safety when other smokers were there at the facility and would report to the staff immediately if she see any activity that was a threat to fire safety.Resident #07:Record review of Resident #07's face sheet dated 06/23/26 reflected a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with diagnoses of dementia, psychotic disturbance, mood disturbance, anxiety, amnesic disorder (a condition characterized by a severe disruption of memory functions) , posttraumatic stress disorder (a mental disorder from experiencing or witnessing a deeply traumatic event), muscle weakness, difficulty in walking, lack of coordination, unsteadiness on feet and age-related cognitive decline. Record review of Resident #07's quarterly MDS dated [DATE] reflected BIMS of 13 which indicated that his cognition was intact.Record review of Resident #07's care plan revealed that none of the care plans after his admission had reflected Resident #07's smoking preference and his risk of injury from smoking.Record review of the smoking evaluations of Resident#07 revealed that the facility conducted a quarterly evaluation on 09/19/25. The evaluation reflected that Resident #07 must be supervised while smoking as he had the history of falling asleep at times while smoking. There were no smoking evaluations performed on Resident #07 after 09/19/25. During an interview on 06/24/26 at 11:30am Resident #07 stated the facility scheduled smoking times and he utilized some of them. He said the cigarettes were stored at the nursing station and staff provided cigarettes when required. He stated he did not have any problem with that arrangement and stated that he followed all the safety rules at the facility while (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking.During an interview on 06/24/26 at 3:30 pm, the ADON stated that routine smoking evaluations were necessary to ensure residents' safety while smoking. She explained that the evaluations, as recommended by the facility policy, were important because they helped identify any changes in residents' conditions. She checked the EHR and observed that some evaluations had not been completed quarterly. She stated that the evaluations were typically completed either by her or the charge nurses. The ADON stated she was unsure why the system did not trigger alerts for residents whose quarterly or annual evaluations were overdue. The ADON stated that she had worked at the facility for about five years, knew all the residents who smoked and was not aware of any changes in their conditions that would need reconciliation of the care plan that required closer supervision at this time.During an interview on 06/24/26 at 3:40 pm, the DON stated that she was new to the facility but had extensive experience as a DON. She stated that periodic smoking evaluations were important to ensure resident safety. She said that routine evaluations helped to identify any changes in residents' conditions that might require additional supervision or other interventions. The DON expressed uncertainty about whether the facility had completed these evaluations quarterly or if the system failed to populate the data correctly.Record review of the facility policy Facility Smoking Policy-Supervised and Unsupervised revised on 07/01/25 reflected : Smoking Evaluation: Residents wishing to smoke while at the facility will have a Smoking Safety Evaluation completed by the interdisciplinary team to determine the resident's ability to follow smoking policies safely.If resident is determined to be a Safe Smoker (Facility please check one option)Resident can smoke unsupervised, resident can keep their smoking supplies, and smoke in designated areas at their leisure.ORResident can smoke unsupervised, facility will keep all smoking supplies, and resident can smoke in designed areas at their leisure. If resident is determined to be an Unsafe Smoker then they must be supervised at all times when smoking. Facility staff will keep all smoking supplies and smoking times will be established by the facility and adhered to by the resident.A supervised smoking schedule will be posted and residents will be required to smoke with supervision only, according to the schedule. Resident smoking evaluations will be conducted:Admit / ReadmitQuarterlyChange in Condition.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Residents #07) reviewed for care plans in that: The facility failed to ensure Resident #07's comprehensive care plan addressed smoking and the risks related to the smoking at the facility. This failure could place residents at the risk of burns and fire hazards. The findings included: Record review of Resident #07's face sheet dated 06/23/26 reflected a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with diagnoses of dementia, psychotic disturbance, mood disturbance, anxiety, amnesic disorder (a condition characterized by a severe disruption of memory functions), posttraumatic stress disorder (a mental disorder from experiencing or witnessing a deeply traumatic event), muscle weakness, difficulty in walking, lack of coordination, unsteadiness on feet and age-related cognitive decline. Record review of Resident #07's quarterly MDS dated [DATE] reflected BIMS of 13 which indicated that his cognition was intact. The MDS had not indicated if he was a user of tobacco. Record review of the quarterly smoking evaluation dated 09/19/2025 reflected that the resident currently smoked. The evaluation reflected Resident #07 had a history of falling asleep at times while smoking, he was not a safe smoker and must be supervised while smoking. Record review of Resident #07's care plans revealed that none of the care plans after his admission addressed Resident #07's smoking preference and his risk of injury from smoking. During an interview on 06/24/26 at 3:20 pm, LVN M stated that she started working at the facility as MDS Coordinator in March 2026. She explained that she was in the process of addressing various issues because there had been no permanent MDS Coordinator at the facility for approximately one year prior to her joining. She stated that after reviewing Resident #07's records, that no care plan had been developed for Resident #07 regarding smoking. She stated that it was her responsibility to complete the care plan assessment and ensure it was done in a timely manner. She added that there were several residents at the facility who smoked, and all of them had care plans, however, she was unsure how Resident #07 was overlooked in the development of a smoking care plan. During an interview on 06/24/26 at 3:30 pm, the ADON stated that she had worked at the facility for about five years and knew Resident #07 very well. She said that Resident #07 required supervision while smoking. She stated that there was not a care plan for smoking for Resident #07. The ADON said that the facility did not have a permanent MDS Coordinator for about a year, and during that time the task was handled by an outside agency or the corporate office. She said that Resident #07 might have been inadvertently omitted from the smoking care plan due to this oversight. She stated that care plans were important for providing quality care, as they serve as a resource for staff to answer nursing-related questions and act as a guide for interventions. During an interview on 06/24/26 at 3:40 pm, the DON stated that a comprehensive care plan was an integral part of person-centered nursing care. She said that a care plan was a relevant document in nursing because it identified residents' issues at the personal level and outlined interventions to address those issues. The DON said that the care plan functioned as a communication tool for the interdisciplinary team, enabling professionals to implement interventions without ambiguity. She stated that Resident #07 was a smoker who required supervision while smoking. The DON stated the absence of a care plan for the resident could pose a safety risk, as staff might not be aware of the need for supervision or the appropriate level of (continued on next page)		

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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 06/24/2026
NAME OF PROVIDER OR SUPPLIER Lily Springs Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Central Texas Exp 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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oversight.Record review of the facility policy Care Plans, Comprehensive Person-Centered revised on 06/02/25 reflected: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and ImplementationThe Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.14. The Interdisciplinary Team must review and update the care plan:When there has been a significant change in the residents' condition.When the desired outcome is not met.When the resident has been readmitted to the facility from a hospital stay; andAt least quarterly, in conjunction with the required quarterly MDS assessment.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 one (Resident #13) of four residents reviewed for infection control. The facility failed to ensure staff practiced hand hygiene when performing perineal care (incontinence care) for Resident #13. The failure put residents at risk for infection, hospitalization, and decreased quality of life. Findings included: Review of Resident #13's face sheet on 6/23/2026 revealed that Resident #13 is a [AGE] year-old female, admitted on [DATE]. Resident #13 has a history of Cerebral infarction due to thrombosis of an unspecified cerebral artery (blood clot blocking blood flow to the brain), chronic obstructive pulmonary disease (difficulty with breathing), malignant neoplasm of the colon (cancerous tumor that develops in the colon), acute on chronic diastolic congestive heart failure (heart's ability to relax and fill with blood is impaired), major depressive disorder (persistent feelings of sadness and loss of interest in activities), dry eye syndrome of the bilateral lacrimal glands (eye does not produce enough tears), macular degeneration (individual can't see things directly in front of them), and neuromuscular dysfunction of the bladder (nerve or brain problems disrupt the normal control of bladder muscles, leading to difficulty storing or emptying urine). Record review of Resident #13's MDS assessment dated [DATE], revealed the resident had a BIMS score of 13.00, which indicated the resident was cognitively intact. Resident #13's MDS revealed that toileting hygiene, shower/bathe self, and personal hygiene required the assistance of 2 or more helpers for the resident to complete these activities. During an observation on 6/23/16 at 10:35 a.m., perineal care for Resident #13 revealed that CNA B did not immediately change her gloves after discarding the soiled brief for Resident #13. CNA B used the same pair of soiled gloves after cleaning the resident's perineal area, then touched Resident #13's blue chucks sheet (cloth placed under the resident to help with changing position and lifting) and Resident #13's unsoiled area during changing Resident #13 from her perineal area to the rectal area. CNA B did not perform any form of hand hygiene (sanitizing hands with alcohol-based hand rub containing at least 62% alcohol or alternatively soap) between glove changes during perineal care. Interview on 06/23/2026 at 11:09 a.m. CNA B stated that she had been working at the facility for 3 years and had become a CNA about 9 months ago. CNA B stated she used the same soiled gloves after cleaning Resident #13's perineum to touch Resident #13 and the chucks sheet underneath her during changing Resident #13's position from the front to the back. CNA B stated she changed gloves before cleaning Resident #13's rectal area. CNA B stated that a negative outcome of not using hand sanitizer between glove changes could cause bacteria to grow and infection. CNA B stated that preventive measures included sanitizing hands between glove changes to prevent the spread of infection and bacteria. CNA B stated she completed all her training, including perineal care competency and in-services, while she started working as a CNA in the facility. CNA B stated that between glove changes, she did not use hand sanitizer or perform any hand hygiene. Interview on 6/24/2026 at 1:36 p.m. RN A stated that at any point, any caregiver who changes their gloves during resident care and puts on new gloves must perform hand hygiene in between glove changes. RN A stated that the caregiver could not use soiled gloves to touch the resident's unsoiled areas, and the resident's clean blue chucks during reposition. RN A stated that failing to perform hand hygiene properly and using soiled gloves to touch the resident could cause the risk of infection. RN A stated that some preventive measures included hand washing, proper precautions, and having a nurse with (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNAs to observe them. Interview on 6/24/2026 at 12:54 p.m. The DON stated that at any point, any caregiver who changes their gloves during resident care and puts on new gloves must perform hand hygiene in between glove changes. The DON stated that the caregiver could not use soiled gloves to touch the residents, and that the residents cleaned their blue chucks during repositioning. The DON stated that failing to perform hand hygiene properly and using soiled gloves to touch residents could lead to cross-contamination and increase the risk of infection. The DON stated that some preventive measures included ensuring caregivers had plenty of gloves and hand sanitizers, and that they changed gloves properly and sanitized their hands between glove changes. Interview on 6/24/2026 at 1:07 p.m. The ADM stated he expected staff members to follow hand-washing policies. The ADM stated that staff members could use gloves and wash their hands after finishing the work. Review of the facility policy titled, Handwashing-Hand Hygiene Policy and Procedures, Revision date 10-2020 revealed that, 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin. m. After removing gloves.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review the facility failed to have the results of the most recent survey of the facility posted in a place readily available to residents, family members, and legal representatives for 1 of 1 survey results books. The facility failed to ensure a binder placed in a bin at the entrance of the facility and titled Survey Binder contained the results of the most recent health recertification survey or all surveys, certifications and complaint/ incident investigations during the 3 preceding years and any plan of correction in effect with respect to the facility. This failure placed residents at risk of not having all the information necessary to make decisions about living at the facility. Findings included: Observation and record review on 06/10/26 at 10:11 AM revealed, a white three-ring binder placed in a clear bin next to the entrance door. The binder had Survey Binder printed on the front. Within the binder were results (Forms 3614, 3630, and 2567) from a health visit dated 04/22/26, were the only available results to view in the binder. The binder did not contain the results of the previous health recertification dated 05/05/25 or any other health visits pertaining to incident or complaint investigations for the 3 proceeding years or their plan of correction if applicable. During a confidential group interview on 06/23/26 at 09:38 AM, 12 of 12 confidential residents stated they did not know where the results of the recent health inspections/ investigations were located and did not believe they were made available to them. During an interview on 06/24/26 at 01:19 PM with the AD, she stated the survey binder was the responsibility of the ADM. She stated the purpose of the survey binder was for family or residents to see the results of the surveys, what was done wrong and corrections. She stated a negative outcome of not having those results available would be it would make them wonder why they don't have the results; it could affect visitors' decisions on the facility. Everyone goes to reviews these days. During an interview on 06/24/26 at 01:49 PM with the ADM, he stated it was the administrator's responsibility to keep up with the survey binder. He stated the purpose of the binder was to inform the public of the latest survey outcome. He stated he believed he had to maintain the last recertification survey and anything after it in the binder. He stated Everyone has a right to it; it's public information and might influence a person's decision to admit someone here. During an interview on 06/24/26 at 02:17 PM the facility policy was requested from the ADM specifically the right to view survey results. The ADM stated there was not a policy specific on the right to view survey results.		