STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675271	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Oaks Nursing & Rehabilitation	901 Seven Oaks Rd Bonham, TX 75418

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on interview and record review the facility failed to immediately notify, consistent with his or her authority, the resident representative(s) when there was a need to alter treatment significantly for 1 of 4 residents (Resident #1) reviewed for notification of changes. The facility failed to notify Resident #1's responsible party of her doppler study results of the lower extremities (noninvasive test that can be used to measure the blood flow through the major blood vessels in the legs), gangrene (localized death and decomposition of body tissue, resulting from either obstructed circulation or bacterial infection) to the right lower extremity, or the need for consultation with a vascular surgeon. This failure could place residents at risk of their responsible parties not being notified or involved in their plan of care. Findings included: Record review of Resident #1's face sheet indicated she was [AGE] years old and readmitted to the facility on [DATE] with diagnoses including, Huntington's disease (inherited condition in which nerve cells in the brain break down over time), history of heart attack, history of acute kidney failure (condition in which the kidneys suddenly can't filter waste from the blood), Type 2 diabetes, history of stroke, hemiplegia/ hemiparesis (muscle weakness or paralysis on one side of the body that can affect the arms, legs, and facial muscles) heart failure, vascular dementia (common form of dementia caused by an impaired supply of blood to the brain), and COVID-19. The face sheet indicated Resident #1's family member was her (Resident #1's) responsible party and medical power of attorney. Record review of Resident #1's quarterly MDS dated [DATE] indicated Resident #1 sometimes understood others and sometimes made herself understood. The MDS indicated Resident #1 had both short-term and long-term memory problems. The MDS indicated Resident #1 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #1 required assistance in the form of set-up or cleanup assistance with eating. The MDS indicated Resident #1 required supervision or touch assistance with oral hygiene. The MDs indicated Resident #1 required substantial/maximal assistance with dressing her upper body. The MDS indicated Resident #1 was completely dependent on staff for toileting, showering, dressing the lower body, and personal hygiene. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675271	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Oaks Nursing & Rehabilitation	901 Seven Oaks Rd Bonham, TX 75418

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan revised on 5/27/24 indicated she had actual skin impairment which included scabbed areas to the great toe and 2nd toe of the right foot. The care plan also indicated she had a bunion area to the right foot. The care plan interventions included identify /document potential causative factors and eliminate/resolve those factors where possible. The interventions also included monitor/document the location, size, and treatment of skin injury and report abnormalities, failure to heal, signs/symptoms of infection and maceration (softening and breaking down of skin resulting from prolonged exposure to moisture) to the medical doctor. Record review of the wound care physician progress note dated 5/31/24 indicated Resident #1 had multiple non-pressure wounds to the right lower extremity. The wound care physician progress note indicated the depth of these wounds could not be assessed due to nonviable tissue and necrosis. The wound care progress directed to obtain an arterial doppler study of the bilateral lower extremities (both the right and left legs). Record review of Resident #1's arterial doppler study dated 6/1/24 revealed Resident #1 had severe arteriosclerosis (when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body (arteries) become thick and stiff - sometimes restricting blood flow to the organs and tissues) to the right lower extremity with near absent blood flow to the right distal SFA (superficial femoral artery), ATA (anterior tibial artery), PTA (posterior tibial artery), and DPA (dorsalis pedis artery). Record review of the podiatry note dated 6/5/24 indicated Resident #1 had wounds on both legs and feet with eschar (dry, dark scab, or falling away of dead skin). The podiatry note indicated the physician had an arterial doppler exam with report which showed decreased to absent blood flow on both lower extremities. The note stated Resident #1 had severe PVD (peripheral vascular disease condition in which narrowed arteries reduce blood flow to the legs or arms). The podiatry note indicated she would be referred to a vascular surgeon for evaluation and treatment. The note indicated Resident #1 would be seen again in the podiatry clinic in 3 weeks. Record review of the wound care physician progress note dated 6/7/24 for Resident #1 revealed that due to Resident #1's severe arteriosclerosis in both the lower extremities and near absent blood flow to the right distal SFA, ATA, PTA, and DPA realistic wound care goals were palliative and not curative. The progress note revealed the wound care physician was relinquishing care to the podiatry physician who had referred her to a vascular surgeon. Record review of the podiatry note dated 6/27/24 indicated Resident #1 had skin to the bilateral extremities cool, thin with multiple wounds with eschar, and her toenails were thickened and discolored. The note indicated Resident #1 had worsening wounds with gangrene (localized death and decomposition of body tissue, resulting from either obstructed circulation or bacterial infection) to the right foot and wounds on both legs and feet stable with eschar covering the wounds. The podiatry note indicated Resident #1 was scheduled with vascular surgeon on 7/26/24 but the podiatry office would attempt to get her in sooner due to the rapid expansion of the gangrene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675271	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Oaks Nursing & Rehabilitation	901 Seven Oaks Rd Bonham, TX 75418

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24 at 10:00 a.m., Resident #1's family member said she was Resident #1's medical power of attorney and responsible party. Resident #1's family member said she was very upset when Resident #1 was admitted to the hospital and saw the state of her right foot. Resident #1's family member said she went to the facility on [DATE] and spoke with the DON and the administrator and learned at that time she (Resident #1) had a doppler study in June. She stated she was never notified of the results, was never notified Resident #1 had gangrene, and was never notified a vascular surgeon would be needed. Record review of the nursing progress notes from 5/28/24 to 7/16/24 did not document Resident #1's family member had been notified of the Doppler study results, gangrene, or plan of care to see a vascular surgeon. During an interview on 7/19/24 at 3:36 p.m., LVN A said she regularly took care of Resident #1 Monday through Friday on 6:00 am to 2:00 p.m. shift. LVN A said she thought Resident #1's family member was aware of the doppler study results. LVN A said she had not notified her of the results because she believed the study was done on a Friday and thought the weekend shift had notified her of the results. LVN A said she was also out the week the doppler results came back. LVN A said she thought Resident #1's family member knew she needed to see a vascular surgeon. LVN A said Resident #1's family member should have been notified with the results and plan of care for Resident #1. During an interview on 7/19/24 at 3:40 p.m., LVN B said she regularly took care of Resident #1 on weekends. LVN B said she worked double weekend shifts and cared for Resident #1 from 6:00 am to 10:00 p.m. LVN B said she thought Resident #1's family member knew about the doppler study results and Resident #1's appointment with the vascular surgeon. She said she had notified the family member herself. LVN B said the weekend supervisor, RN C, would be the one to contact families on the weekend and update with items such as the doppler study results. LVN B said Resident #1's family member had the right to be notified of the doppler study results and plan of care. During an interview on 7/19/24 at 3:47 p.m. RN C said she did not know if the results of the doppler study results had been communicated to Resident #1's family member. RN C said Resident #1's family member should have been notified. During an interview on 7/19/24 at 3:56 p.m. LVN D said she regularly took care of Resident #1 Monday through Friday on the 2:00 p.m. to 10:00 p.m. shift. LVN D said she had not personally contacted the Resident #1's family member about Resident #1's doppler study. LVN D said Resident #1's family member should have been contacted because she (the resident's family member) had the right to know what was going on with Resident #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675271	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Oaks Nursing & Rehabilitation	901 Seven Oaks Rd Bonham, TX 75418

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24 at 4:00 p.m., the DON said she could not say if Resident #1's family member was notified of the doppler study results and could not remember if that was something she had spoken with her (Resident #1's family member) about. The DON said Resident #1's family member had the right to know what was going on, should have been notified, and the notification should have been documented. The DON said she did not know if it was communicated that the Resident had gangrene to the right foot. The DON explained the podiatry notes were sent via email and that the staff nurses would not have seen those results to communicate them to Resident #1's family. The DON explained during the time of doppler study and last podiatry visit there was a COVID-19 outbreak in the building and as result, she was working the floor often. The DON said she knew she had spoken with Resident #1's family member about the non-pressure wounds to her right foot but again could not say if she specially spoke with her about the doppler study and the gangrene. During an interview on 7/19/24 at 4:10 p.m., the Administrator said she did not know if Resident #1's family member had been notified specifically of the doppler study results. The Administrator said she felt perhaps the gravity of situation was not communicated well with Resident #1's family member and that communication with families would get better. Record review of the facility policy and procedure titled, Notifying the Physician of Change in Status revised 3/11/2013 stated . (5) the resident's family member or legal guardian should be notified of significant change in resident's status . (7) the nurse will document .all attempts to notify the family and/or legal representative .