STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675736	A. Building B. Wing	06/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yoakum Nursing and Rehabilitation Center	1300 Carl Ramert Dr Yoakum, TX 77995

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observation, interview and record review, the facility failed to ensure the residents' right to be free from abuse for one (Resident #1) of 7 residents reviewed for abuse. The facility failed to prevent Resident #1 from being abused when a rubber band was discovered wrapped 4-5 times around the shaft of his penis on 6/07/2024 at approximately 2:00 AM. The non-compliance was identified as past non-compliance (PNC). The PNC IJ began on 06/07/24 and ended on 06/08/24. The facility had corrected the non-compliance before the state's investigation began on 6/08/2024 8:00 AM. This failure could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. The findings included: Record review of the Admission Record, dated 6/09/2024, reflected Resident #1 was a [AGE] year-old male originally admitted on [DATE]. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the quarterly MDS assessment, dated 3/27/2024, reflected Resident #1 had a BIMS summary score of 3, indicative of severe cognitive impairment. Under section E - Behavior, Resident #1 was documented with a lack of behavioral symptoms: did not exhibit the behavior of rejection of care; did not exhibit physical behavioral symptoms directed toward others. Under section GG - Functional Abilities and Goals, Resident #1 was documented as impairment on one side of both upper and lower extremities; Resident #1 routinely used a wheelchair for mobility; Resident #1 was coded as dependent for eating, oral hygiene, toileting hygiene, shower/bathe self. Resident #1 was coded as dependent in the following activities: lower body dressing, putting on/taking off footwear, personal hygiene, sit to lying transition, lying to sitting on one side transition, chair/bed-to-chair transfer. Resident #1 was coded as dependent in the following activities: wheel 50 feet with two turns, wheel 150 feet. Under section H - Bladder and Bowel, Resident #1 was coded as always incontinent of bowel and bladder and was not utilizing a toileting program to manage continence. Resident #1's primary medical condition category that best described the primary reason for admission was coded as medically complex conditions related to unspecified dementia without behavioral disturbance. Other active diagnoses included diabetes mellitus, hemiplegia or hemiparesis [weakness to one side of the body], seizure disorder or epilepsy, contractures [permanent tightening of the muscles, tendons, skin and surrounding tissues that causes the joints to shorten and stiffen] : right hand, left and right knee, left and right hip, and right elbow. Resident #1 was coded as unable to answer, Have you had pain or hurting at any time in the last 5 days? Under section M - skin conditions, Resident #1 had a clinical assessment that determined he was a risk of developing pressure ulcers/injuries. Record review of the Care Plan reflected Resident #1 had a focus area of [Resident #1] was subjected to allegations of abuse as evidenced by a rubber band found wrapped around penis with a date initiated of 6/07/2024, and a revision on 6/08/2024. Interventions included the following: administer clobetasol [potent corticosteroid topical treatment for inflammation and pain] and solumedrol [intramuscular corticosteroid that reduces inflammation, pain, swelling, redness, heat]; apply ice packs; monitor and provide patient with as needed pain medication; monitor for swelling and follow orders; monitor penis for change in condition; monitor for urinary output; notify the medical doctor of any further complications/new developments of adverse effects. Further focus areas included: [Resident #1] was passive and receives one-on-one visits . with a revision on 1/25/2022; [Resident #1] had an ADL self-care performance deficit related to .confusion, hemiplegia . with a revision date of 4/20/2021. Interventions included the following: totally dependent on staff to provide shower and or bed bath; totally dependent on staff for repositioning and turning in bed; totally dependent on staff for dressing; extensive to total assistance by staff to eat; totally dependent on staff for personal hygiene and oral care; incontinent of bowel and bladder causing Resident #1 to be totally dependent on staff for toilet use; required mechanical Hoyer lift with 2 staff for transfers. Additional focus areas, [Resident #1] had limited physical mobility related to contractures and stroke, with a revision date of 3/29/2024. [Resident #1] had a history of stroke affecting cognition, communication ability and right sided hemiplegia with a revision date of 11/07/2018. [Resident #1] had bowel/bladder incontinence related to cognitive impairment diagnosis of dementia with a revision date of 4/20/2021. Interventions included the following: use disposable briefs, change every 2 hours, and as needed; check every 2 hours and as required for incontinence. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Nurses Note, authored by RN D dated 6/07/2024 at 3:21 AM reflected, called to Residents Room by [CNA B]; found resident with rubber band wrapped around shaft of penis 4 to 5 times. Thick rubber band constricting resident from urinating .unable to remove rubber band by hand; had to use scissors to cut [rubber band] off; upon release resident started urinating large amount of urine . Resident #1's responsible party was left a message regarding the incident. NP I was notified as she was on-call for MD H. Resident #1 was administered 1000 milligrams of Tylenol [a medication used to treat fever, pain and inflammation]. Record review of Nurses Note, authored by RN C late entry for 6/7/2024 at 2:00 AM reflected, initiation of incident report and notification of the abuse coordinator. RN C reassessed Resident #1 an hour after initial incident and noted no signs or symptoms of discomfort and penis noted to not be as swollen. RN C documented urination and bowel movement between discovery of the incident and the reassessment at 3:00 AM. In an observation on 6/08/2024 at 9:40 AM, revealed Resident #1 was lying supine in bed, with the head of bed elevated 30-45 degrees, with the linens pulled up to axillae [arm pit]. Resident #1 had his eyes open but did not respond to verbal stimuli. Resident #1 did not maintain eye contact or tract movement with his eyes. Resident #1 appeared awake but was not responsive to the surveyor. He exhibited slow deep breaths, and a relaxed body and facial expression with no overt signs of distress. In an interview on 6/08/2024 at 11:00 AM, NA A stated she was the staff member responsible for providing care to Resident #1 on the 6A-6P shift on Thursday 6/06/2024. NA A stated she had been working at the facility for almost 6 months so far. NA A stated she had no other interventions she knew of to make caring for Resident #1 easier. NA A stated that Resident #1 was easy to care for; he was incontinent of bowel and bladder; and could not really converse, he would just repeat back what he heard [echolalia]. NA A stated she was new and had not yet learned how to document in the electronic health record, so that other staff would enter her tasks as completed for her. NA A stated she had provided him a shower after lunch but was unsure of the time. NA A stated that during the shower Resident #1 was incontinent of bowel and bladder. NA A stated at that time there was no rubber band around his penis. NA A stated she did not know how the rubber band got around Resident #1's penis. NA A stated she did not believe that Resident #1 would be able to do that himself. NA A stated that after showering Resident #1, she had an in-service that took approximately half an hour and then she had her 30-minute lunch break at 2:40 PM. Upon returning from lunch [approximately 3:15 PM], it was then time to assist Resident #1 to the dining room for dinner. [Subsequent interviews with more tenured staff indicate that seating for the evening meal starts no earlier than 4:30 PM.] NA A stated she was not the person that assisted Resident #1 to return to his room after dinner, or assist him from his wheelchair to bed, which was his known preference. NA A stated she was assisting Resident #2 after dining and noted that Resident #1 was in bed at the end of her shift. NA A stated she did not know who put Resident #1 to bed the evening of 6/06/2024. NA A stated she assumed that whoever had assisted Resident #1 to bed had also provided incontinence checks to Resident #1 as that task was supposed to be done before the end of the shift as per facility practice. NA A stated she left the floor at approximately 6:10-6:15 PM the evening of 6/06/2024. NA A stated the last time she provided any care to Resident #1 was when she showered him, and during that shower Resident #1 had a bowel movement and was incontinent of urine in the shower. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 6/08/2024 at 11:20 AM, the DON stated as she was walking by, she saw Resident #1 was sliding down his wheelchair in his room after dinner on 6/06/2024. The DON stated she called out to CNA F to assist her with getting Resident #1 repositioned from his wheelchair on to his bed. The DON stated she and CNA F used a mechanical lift to place Resident #1 on the bed, on top of the fitted sheet without providing an incontinence check. The DON stated she expected the person assigned to provide care for Resident #1 to check for incontinence and assist Resident #1 into his night clothes before the end of the shift. The DON stated that would have been NA A on the 6A-6P shift on 6/06/2024. The DON stated, It was pushing close to the end of shift, maybe 5:50 to 6 o'clock [in the evening] when we [the DON and CNA F] assisted [Resident #1] to the bed . In a joint interview on 6/08/2023 at 12:30 PM, the ADM stated she was the abuse coordinator for the facility. The ADM stated she was notified just after 2:00 or 2:30 AM on 6/07/2024 that Resident #1 had been discovered with a rubber band around his penis. The DON stated she was notified around 2:30 AM on 6/07/2024. The ADM stated that she initiated an investigation immediately by interviewing staff on site and then by telephone. The ADM stated that there were inconsistencies in the explanation NA A provided detailing when she provided care to Resident #1. Additionally, the DON stated it was unusual that NA A did not document any provision of care to any resident on 6/06/2024. The ADM stated that NA A indicated that CNA F was present during all provision of care to Resident #1 on 6/06/2024. This prompted the ADM to re-interview CNA F. The ADM stated that CNA F denied being asked to help NA A by NA A or any other staff on 6/06/2024. The ADM stated at this point she suspended NA A pending the outcome of the investigation. The DON stated in-service trainings were initiated with all nursing staff working the 6A-6P shift on Friday 6/07/2024 before they were allowed to work with residents. The DON stated she included non-nursing but direct care, such as habilitation therapy staff and non-direct care staff, such as laundry personnel, with that training. The DON stated she trained each on coming shift there after before they were allowed to work with residents. The DON stated she did not believe Resident #1 had the cognitive acuity or the physical dexterity to put a rubber band around his penis. The DON stated she inspected carts and nurses' station for access to rubber bands, but could not find any that would be accessible to Resident #1. In an interview on 6/08/2024 at 2:42 PM, RN J stated she was the nurse assigned to Resident #1 on 6/06/2024 6A-6P shift. RN J stated Resident #1 can sometimes answer very simple and immediate yes/no type questions. RN J stated Resident #1 had a stroke and had cognitive deficits and only had use of one arm. RN J stated she did not believe that Resident #1 would be able to figure out how to put a rubber band around his penis and did not think he had the manual dexterity to do so. RN J stated that Resident #1 was always incontinent of bowel and bladder and needed frequent incontinent care. RN J stated she rounded on Resident #1 several times on 6/06/2024 and did not observe any overt signs of distress, abuse or neglect. RN J stated she did not perform any incontinent care or skin checks on Resident #1 that day. RN J stated Resident #1 had not displayed any subsequent signs of discomfort or distress since the rubber band was discovered. In an interview on 6/08/2024 at 5:36 PM, RN D stated she was not the nurse assigned to Resident #1 but had been called over by CNA B at approximately 2:00 AM. RN D stated she entered the room with CNA B and RN C and observed that a rubber band had been tightly wound around Resident #1 penis. RN D stated she attempted to unwind the rubber band, but had to use scissors to release the rubber band. RN D stated Resident #1 did not appear in pain or in any distress, and that he immediately urinated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/08/2024 at 5:47 PM, RN C stated she was the nurse assigned to Resident #1. RN C stated she followed RN D and CNA B into Resident #1's room when she heard CNA B ask for assistance. RN C stated she observed a rubber band around Resident #1's penis. RN C stated it was wrapped so tightly that they were unable to remove it by hand, and it required two snips of scissors to release the rubber band. RN C stated she stayed with and assessed the resident while RN D left the room to start an incident report and make the required notifications. RN C stated once that was complete, RN C and RN D both made rounds on all residents, starting on the 300 hallway and continuing throughout the building, to assess for any other concerns of abuse or neglect on any resident. In an interview on 6/08/2024 at 6:10 PM, CNA E stated she was assigned the area of the hallway for Resident #1 on Thursday 6/06/2024 from 6 PM to 10 PM. CNA E stated she did not see the off going aide [NA A] and no shift change report was done. CNA E stated that was not unusual, as not all CNAs talked at shift change, and even then, would only do a mini report if something significant was going on with a particular resident. CNA E stated she had assisted Resident #1's roommate, Resident #5 to bed at around 6:30 PM on Thursday 6/06/2024, when she noticed that Resident #1 was already in bed, with his night gown on, but Resident #1 still had his pants from earlier in the day on but they were pulled down lower on his hips. CNA E stated she was thankful for that because it made it easier to remove his pants and do a check of the brief to get Resident #1 ready for bed. CNA E stated she could see from the outside of the brief there was no urine, and from the back she could tell there was no feces in the brief. CNA E stated she did not open the brief to look inside. CNA E stated she did another check on Resident #1 around 8:30 PM on 6/06/2024 and again there was no bowel movement or urine visible from the outside of his brief, and she did not open the brief to look inside . CNA E stated she was not aware of the rubber band around Resident #1's penis. CNA E stated she had received in-servicing after the incident that included abuse and neglect, the correct way to perform an incontinence check and reporting change in condition requirements. In an interview on 6/08/2024 at 6:40 PM, CNA B stated she had started her shift at 10:00 PM on Thursday 6/06/2024. CNA B checked on Resident #1 at about 11:00 PM but did not see any urine or feces in the brief from the outside. CNA B stated she did not open the brief to inspect inside it at that time. CNA B stated she next checked on Resident #1 at about 1:45 AM on 6/07/2024. CNA B stated that when she checked from the outside, Resident #1 still appeared to have no bowel movement or urine in the brief, and that prompted her to investigate further. CNA B stated she had worked at the facility long enough to know that Resident #1 was frequently incontinent of bowel and bladder, and almost always required incontinence care every 2 hours. CNA B stated one dry brief was a favor, but 2 dry briefs in a row felt like something was wrong with Resident #1. CNA B stated that when she opened the brief to check Resident #1, she found a rubber band wrapped tightly around the shaft of Resident #1's penis. CNA B stated she immediately went to get the first nurse she could find. CNA B stated Resident #1 was sleeping lightly and had not seemed distressed at any point during her shift. CNA B stated the nurses (RN D and RN C) were able to quickly get the rubber band off Resident #1 with scissors, and Resident #1 immediately started urinating a strong stream. CNA B stated as soon as Resident #1 was situated, she immediately began checking on all the residents on her workload. CNA B stated the nurses were doing full body checks and looking to see if the residents seemed bothered by anything. CNA B stated she had not worked at the facility since the incident, but had been told that she would have to complete in-service training before starting her next shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 6/09/2024 at 12:35 PM, MD H stated that the on-call NP had been notified first, since he was on vacation, but he had been apprised of the situation upon his return. MD H stated that the swelling Resident #1 was still experiencing was not unexpected. MD H stated that over the next 7 to 10 days, barring any complications, the swelling and discoloration should resolve with the current conservative course of treatment. MD H stated it was good that urine was able to flow immediately, and the swelling and discomfort seemed only moderate. MD H stated if the rubber band had not been found when it was and immediately removed, the consequences could have been dire, including total loss of the penis. In an interview on 6/9/2024 at 1:15 PM, the DON stated in-service training was initiated on 6/7/2024 at the start of the 6 AM shift with every worker on site since the incident was discovered. The DON stated the in-servicing curriculum was explicit in that nothing should be wrapped around genitalia with out a direct order from the provider. The DON stated the in-service training would change how the facility would approach incontinence checks. The DON stated that briefs would now need to be opened for the interior of the brief and skin of the perineum to be visualized. The DON stated that abuse prohibition policies were included in in-service training that was initiated in response to the incident with Resident #1. The DON stated that no staff would be allowed to work with residents until they had had the in-servicing. The DON stated any new, agency or staff pulled from a sister facility would be trained before being allowed to work with residents. The DON stated the investigation was started immediately upon discovery of the rubber band around Resident #1's penis. All residents were assessed for emotional or physical signs and symptoms of distress, abuse or mistreatment. Record review of Abuse Prevention Program policy, updated September 2018, reflected policy statement, committed to protecting our residents from abuse by anyone including but not necessarily limited to: employees, other residents, consultants, volunteers, agents or power of attorney, and or staff from other agencies providing services to our residents. Policies and procedures that govern .identification of occurrences, and patterns of potential mistreatment/abuse, protection of residents. Reporting of Alleged Abuse, updated September 2018, included definition of abuse as: willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Record review of Skin Assessments revealed all 29 residents on 300 hallway received assessments 6/07/2024; followed by the remaining 57 residents of the other hallways, totaling 86 residents assessed. Record review of In-Service Sign In sheet started 6/07/2024, reflected the following topics: Abuse and Neglect prohibition and policy; Proper Incontinent Care; Changes in Condition (notify charge nurse immediately). 22 of 22 nursing staff scheduled to work on Friday 6/07/2024 were trained on 6/07/2024 prior to working with residents included: 3 of 3 day shift nurses, the Treatment Nurse, 2 of 2 MAs, 11 of 11 day shift CNAs, 2 of 2 night shift nurses, 4 of 4 night shift CNAs. 6 of 6 nursing staff not previously scheduled to work on Friday 6/07/2024, who worked on Saturday 6/08/2024 were trained on 6/08/2024 prior to working with residents included: 2 of 2 MAs, 3 of 3 day shift CNAs, and 1 of 1 night shift CNAs. 5 of 5 nursing staff not previously scheduled to work on Friday 6/07/2024 or Saturday 6/08/2024, who worked on Sunday 6/09/2024 were trained on 6/09/2024 prior to working with residents included: 3 of 3 dayshift CNAs, and 2 night shift CNAs. A total of 51 staff that included direct and non-direct care/non-Nursing Staff were trained starting on 6/07/2023 prior to the start of their shift, included the following departments: accounting, dietary, habilitation therapy, social services, business office, human resources, receptionist, housekeeping, and laundry. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interviews starting on 6/08/2024 8:00 am through 6/09/2024 5:45 PM, 20 staff interviews indicated, if they had worked since the incident with Resident #1, they had received training prior to working with any resident. If they had not been scheduled to work yet, they had been informed they must be in-serviced prior to working with any resident. In-servicing topics included: included: abuse and neglect: definitions, signs and symptoms, reporting requirements; change in conditions; and new protocols for incontinence checks to open brief to visualize interior and residents' perineum. Record review of Provider Investigation Report addendum received 6/7/2024 at 12:45 PM revealed ADM was notified at 2:08 AM of incident with Resident #1. ADM arrived at the facility within 15 minutes to initiate investigation. Ad-Hoc QAPI meeting held to discuss the incident. Additionally, local police department was notified, and provided a police report number 24-3584. Facility suspended the suspected Alleged Perpetrator, NA A, prior to entrance on 6/08/2024.