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	08/07/2024

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 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** 48753 Based on interview and record review the facility failed to ensure that the comprehensive person-centered care plan described services that are to be furnished to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #1) reviewed for care plans, in that: Resident #1's care plan, undated, did not indicate that Resident #1 was on a regular diet consisting of mechanical soft texture and regular liquids as of 6/18/2024. Resident #1's care plan inaccurately indicated Resident #1 was NPO status, onset date 05/29/2024. This deficient practice could affect residents who had a diet order change by serving a resident the wrong diet. The findings included: Record review of Resident #1's face sheet, undated, reflected Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of traumatic subdural hemorrhage (type of bleeding in which a collection of blood gathers between parts of the brain usually caused by a severe head injury) and dysphagia (difficulty speaking). Record review of Resident #1's admission MDS assessment, dated 06/03/2024, reflected Resident #1 had a BIMS score of 8, indicating moderate cognitive impairment. Record review of Resident #1's June 2024 administration record, reflected Resident #1 had an enteral feed order: six times a day for provide 2130kcal, 91g pro, 2280ml total water [brand name] 1.5 bolus feeding x 6 cans/day + 100ml flush before and after q feed, start date 06/03/2024 and discontinued date, 06/19/2024. Resident #1 had an enteral feed order: three times a day bolus 2 cans of [brand name] 1.5 after meals if PO intake is < 50%, start date 06/19/2024. Record review of Resident #1's physician order summary for June 2024, reflected Resident #1 had an order for regular diet: mechanical soft texture and regular liquids, start date 06/18/2024. Record review of Resident #1's nutrition/dietary note, dated 06/19/2024, reflected, Diet: regular diet, mech soft texture, regular liquids. Noted diet started 06/18/2024 per ST recommendations. PO intake 75%-100% no supplements ordered. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, undated, reflected Resident #1 has a care plan [Resident #1 first name] has a swallowing problem r/t dysphagia. He is NPO and received g-tube feedings, dated initiated 06/12/2024. The goal of the care plan stated, the resident will maintain weight and nutritional balance through the review date, dated initiated, 06/12/2024 and target date, 09/10/2024. Record review of Resident #1's weights revealed Resident weighed 157.4 on 05/29/2024 and 159.0 on 08/05/2024 indicating Resident #1 had not lost weight. During an interview with Resident #1, 08/07/2024 at 10:00 a.m., Resident #1 revealed he had been receiving food and medication orally since sometime in June. During an interview with LVN A, 08/07/2024 at 12:29 p.m., LVN A stated she was the Charge Nurse for Resident #1 and Resident #1 ate meals by mouth and was administered medications by mouth. LVN A stated Resident #1 had an order for bolus feeding if Resident #1 ate less than 50% but he has not needed that in months. LVN A stated the accuracy of a resident's care plan was important because It is what we go by to provide proper care for each resident. During an interview with MDS LVN B, 08/07/2024 at 1:51 p.m., MDS LVN B stated resident care plans should be updated whenever something happens like a fall, bruise, medication change, behavior or anything that is a change. MDS LVN B said the accuracy of resident care plans was important so staff can see what the plan of care is for the resident and so staff know how to care for the resident. MDS LVN B said a resident's care plan that was inaccurate could cause harm by injury or death. During an interview with MDS LVN A, 08/07/2024 at 2:03 p.m., MDS LVN A revealed Resident #1 was not NPO and stated Resident #1 was eating and drinking orally. MDS LVN A revealed she and another MDS Nurse were responsible for initiating a resident care plan upon admission and the nurse managers assist with updating the care plans during the start-up morning meeting. MDS LVN A stated care plans should be updated daily, if there are any changes and MDS LVN A stated the accuracy of the resident care plan was important because it is for everyone to see how to care for a resident and what to do. MDS LVN A stated Resident #1's NPO care plan could have potentially caused Resident #1 to not get his meals, nutrition and fluids. During an interview with the DON, 08/07/2024 at 2:45 p.m., the DON stated the nursing team checked resident orders every morning and resident care plans should have been updated by the MDS nurses or ADONs. The DON stated the accuracy of the care plans was important because it is our plan of care for the patient and if anyone needs to know how to care for the patient, they can check the care plan. The DON stated the MDS nurses had received training on care plans annually and stated, we just had an all-day training on care plans last week in a regional training. Record review of facility policy titled Comprehensive Care Plans, date implemented 10/24/2022, reflected it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment.