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	08/14/2024

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 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** 34957 Based on observation, interview and record review, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 4 residents (Resident #1) reviewed for notification of changes, in that: Resident #1 developed new wounds on 08/01/24 and the resident representative (RP) was not informed until 08/02/24 by facility staff. This failure could lead to the facility making decisions without the resident's right to designate a surrogate or representative to make treatment or transfer decisions for the resident; and could deny the resident through the resident representative their wishes and preferences. The findings included: Record review of Resident #1's face sheet, dated 8/13/24, male age 72, reflected, the resident was admitted on [DATE] and discharge 8/2/24 to home with diagnoses that included: POSTCHOLECYSTECTOMY SYNDROME (removal of the gall bladder at admissions); CALCULUS OF KIDNEY WITH CALCULUS OF URETER (kidney stone), TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE [from history of stroke], PERIPHERAL VASCULAR DISEASE, UNSPECIFIED [poor blood circulation], COLOSTOMY STATUS, UNSPECIFIED OSTEOARTHRITIS [weak bones]. RP (responsible party) was listed as: a family member. Record review of Resident #1's Significant Change (weight loss) MDS (minimum data set), dated 7/30/24, reflected: A BIMS (brief interview of mental status) Score was 8 meaning (moderate impairment); and the ADLs (activities of daily living) reflected : B/B (bowel and bladder)- and Resident #1 had a colostomy and was incontinent for urine. Transfer was mechanical lift for Resident #1. Bed Mobility was total assist and the ROM (range of motion) was total; to upper and lower. Record review of Resident #1's CP (care plan), undated, reflected: Resident#1 had the potential for pressure ulcer development related to immobility and history of CVA (cerebrovascular accident) Hemiplegia, and Hemiparesis (stroke). Resident #1 has the potential for pressure ulcer development related to Immobility: and a history of CVA Hemiplegia, and Hemiparesis (stroke). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Wound Physician Assessments, dated below, reflected: 7/8/24: Right Second Toe: measurements: 7 (L) X 7 (W) X 0.1 (D). 7/25/24: Right Second Toe: measurements: .6X 6X.1. Left lateral leg 4X4X no depth (dead tissue). 8/1/24: Right second Toe: measurements .6X.6X Depth (not measurable) (dead tissue and narcosis) Left lateral measurements:4X4X (Depth) not measurable Buttocks 4.5X2.5X0.1 Right heel 3.5X3.0XDepth (not measurable) (necrosis). During an interview on 8/13/24 at 10:29 AM, LVN A stated: on 8/1/24 the Wound Care Specialist identified left buttocks (8/1/24) wound, left lateral leg (7/25/24) wound and right second toe (7/18/24). LVN A stated the resident was not admitted with any wounds. LVN A stated that the wounds developed because of Resident's diabetes, stroke, and poor blood circulation. Resident could not move his left lateral leg (side of stroke). LVN A stated the wounds were All arterial wounds. LVN A stated the wounds were unavoidable because of the resident's comorbidities and declining health. LVN A stated the resident did not want to be in the nursing home and refused to eat. LVN A stated that PT (physical therapy), SP (speech therapy) and OT (occupational therapy) were all working with the resident to encourage eating, strength building, and mobility. LVN A stated that she had no information as to whether the RP was notified on 08/01/24 when Resident #1 was found to have developed new wounds. During an interview on 6/13/24 at 1:19 PM, LVN B stated: the resident (Resident #1) was developing wounds due to not eating, poor vascular circulation, diabetes, dementia, and refused care (not wanting to leave his bed) LVN B stated she kept the RP verbally informed but may not have documented the 8/1/24 communications with the RP. LVN B stated that RP was informed on 7/25/24 about the new arterial left lateral leg wound. LVN B stated she did not know the reason the RP wanted to discharge the resident home. During an interview on 8/13/24 at 1:41 PM, NA C stated: she provided bed baths to the resident (Resident #1) in the month of July 2024. NA C stated that part of giving a bed bath was documenting any wounds in the POC (point of care used by nurse aides to document activities of daily living)). NA C stated that she saw a wound on the Resident #1's buttocks and on his leg in July 2024. NA C stated, I did not know I had to tell the nurse about the wounds I saw except to document in POC. NA C stated that she often saw the RP present in the resident's room. NA C stated that as part of HIPAA she did not communicate to the RP about the wounds she saw. During an interview on 8/13/24 at 1:55 PM, LVN D stated: she provided nursing care to Resident #1 which included: medication administration, monitoring, vital signs and assessments every day, and coordination of care. LVN D stated that the RP was present almost every day. LVN D stated she kept the RP informed about the resident's refusal not to eat and the loss of weight and the interventions attempted by the physician. LVN D stated that the verbal communications about the Resident's wounds were not documented. LVN stated that it (new wounds) needed to be documented otherwise it didn't happen. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/24 at 2:19 PM, the DON stated: Resident #1 refused to eat, and interventions included: referral to SP, weekly weights, getting the RP involved, orders for ensure (supplement) and milkshakes. The DON stated that Resident #1 developed wounds after 30 days not eating and not wanting to get out of bed. The DON stated that the RP had been informed about the resident's decline on 7/25/24 and that the resident would accrue more wounds. The DON stated that the new wounds assessed by the Wound Care Specialist on 8/1/24, she stated she needed to check to determine whether the RP was informed on 8/1/14. During a telephone interview on 8/13/24 at 2:57 PM, the RP stated that the facility never told her about the new wounds identified by the wound physician on 8/1/24. The RP stated the wounds were totally new and the staff never told me. The RP stated that during a mechanical lift on 7/30/24 she noticed the buttock wound. During a telephone interview on 8/13/24 at 3:05 PM, the Wound Care Specialist stated: the resident (Resident #1) loss weight because he did not want to eat. Interventions were attempted to include IV fluids. The Wound Care Specialist. The Wound Care Specialist The Wound Care Specialist. The Wound Care Specialist, The Wound Care Specialist stated: the resident developed wounds because or arterial vascular issues, co-morbidities, and did not want to leave his bed. The Wound Care Specialist. The Wound Care Specialist stated: that his belief was that the RP was kept informed about the resident's refusal to eat and worsening condition. During observation and interview on 8/14/24 at 8:30 AM, reflected Resident #1 was in bed in a community rehabilitation hospital. Observation revealed the resident was alert and oriented to person, place and time. The resident received by IV an antibiotic (daptomycin 500 mg); and right toe was bandaged, and there was a pressure release boot on the left leg. Resident #1 stated that the care at the nursing home was not good [but provided no specifics]. The resident stated he lost weight at the nursing home because he did not like the food and stopped eating for 30 days. The resident stated the facility offered him milkshakes and appetite stimulants and alternate diets; but he did not want to eat. The resident stated he developed wounds in the nursing home but did not know the cause of the wounds. The resident stated that he preferred to stay in bed and had a wound to his buttocks which caused him to want to be in bed. The Resident stated the facility made efforts to move him out of bed; and he did not remember about staff re-positioning him. The resident stated his right toe was amputated and he had a history of diabetes. Resident #1 stated his plan was to return home after the current hospital and rehab stays. When asked about the RP being kept informed about changes in his medical condition, Resident #1 stated: I do not think so . they were not notifying my (RP) as my condition was worsening. Record review of facility's Resident Rights policy dated 10/24/22 reflected: .The facility will periodically assess the resident for decision making abilities and approach the health care proxy or legal representative if the resident is determined not to make decision making capacities. After exit on 8/14/24, the facility provided by email Resident #1's Weekly Wound Progress Note authored by LVN B which reflected resident developed new wounds on 08/01/2024 and the RP was notified on 08/02/2024 00:00 (midnight).