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	02/14/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure residents had the right to be free from misappropriation of resident property for 2 of 3 Residents (Resident #4 and Resident #5) whose records were reviewed for misappropriation of medications. 1. Nursing staff did not follow procedures when re-ordering Ativan for Resident #4; two Ativan tabs were unaccounted for after an exchange of a 30 day blister pack between MA G and LVN A . 2. MA G failed to sign off after administering Resident #5's scheduled Ativan 0.5 MG tab. These deficient practices could affect residents prescribed controlled medications and could result in the misappropriation of resident's medications. The findings were: 1. Review of Resident #4's face sheet, dated 2/14/25, revealed he was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Bipolar Disorder and Anxiety Disorder, Unspecified. Review of Resident #4's quarterly MDS assessment, dated 12/0/24, revealed his BIMS score was 6 of 15 reflective of severe cognitive impairment and he had diagnoses of Anxiety, Depression and Bipolar and he received anti-anxiety and anti-depression medications. Review of Resident #4's Care Plan, revised 10/18/24, revealed he was receiving anti-anxiety medications related to Anxiety. One of the interventions read: Administer ANTI-ANXIETY Ativan medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Review of Resident #4's consolidated physician orders for April 2024 revealed he an order for Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth one time a day related to OTHER SPECIFIED ANXIETY DISORDERS. Review of Resident #4's MAR for April 2024 revealed he received Ativan daily per physician orders. Review of Provider Investigation Report, dated 4/30/24, read in part: Incident: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675736	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER: Yoakum Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1300 Carl Ramert Dr Yoakum, TX 77995	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 23, 2024, at approximately 7:45 p.m. Administrator [name] was notified by Director of Nursing [name] that a blister pack of Ativan was not accurately accounted for in medication cart and when located at nurses' station two pills were missing from blister pack. Further review of the investigation revealed MA G and LVN A were both interviewed. MA G's interview read: Administrator and Treatment Nurse interviewed Certified Medication Aide G [name]. [name] MA G states that at approximately 9:30 a.m. on April 23, 2024, she gave her Charge Nurse, LVN A [name] a blister pack of Ativan for Resident #4 [name] with two pills in the blister pack. She states that she informed Charge Nurse that the resident had two pills left and needed to be re ordered. MA G [name] states that at 7:15 p.m. she began to count her cart with Charge Nurse, LVN H [name]. At this time LVN H [name] would not take over the cart because the blister pack of Ativan was missing from the cart. MA G [name] recalled giving the blister pack to LVN A [name] and it not being returned. Charge Nurse, LVN H, [name] began looking for it at the nurses station and it was located between a stack of papers. The blister pack was missing two pills and was empty. Charge Nurse, LVN H [name] immediately notified Director of Nursing [name]. LVN A interview read: Administrator and Treatment Nurse interviewed LVN A [name]. LVN A [name] states that at approximately 10 a.m.-12 p.m. MA G [name] brought her a blister pack of Ativan for Resident #4 [name]. LVN A [name] states that she reviewed the blister pack and it stated no refills. At that time she wrote a note to Dr. [name] to be faxed requesting refills. LVN A [name] states that when she looked at the blister pack there were no pills in the blister pack. LVN A [name] states that she put the blister pack with her fax and set it at nurses station. Interview on 2/14/25 at 12:59 PM with MA G revealed she remembered the incident with the missing Ativan for Resident #4. She stated she pulled the card, blister pack, because she noticed there were only 2 tabs left. She took LVN A the card and let the nurse know there were only 2 tabs left. MA G stated LVN A took the card without question. MA G stated she knew she was not supposed to pull a narcotic card out of the cart under any circumstances unless another nurse verified the count with her prior to pulling it. She stated she wanted to show LVN A that she needed to re-order the Ativan for Resident #4. She stated she could have called her on the phone but did not. MA G stated she understood 2 tablets went missing and again stated she saw 2 tablets left in the Ativan card. MA G stated she did not take the 2 tablets. Interview on 2/12/25 at 4:50 PM with the DON revealed she vaguely remembered the incident because it was after hours and the ADM took the lead with the investigation. She stated she understood 2 Ativan tabs were not accounted for Resident #4. She reiterated MA G pulled the card and gave it to LVN A. When the relieving nurse, LVN H, reported for shift, she noted the card was not in the cart and asked MA G about it. MA G reported she gave it to LVN A with 2 tabs left. The DON stated she called LVN A who reported it was at the nurses station with paperwork but stated the card had 2 remaining Ativan tabs. LVN A stated she called the PCP who reordered Resident #4's medications. Resident #4 did not miss any scheduled doses of Ativan. The DON stated the relieving LVN H found the card and it did not have the 2 tabs in question. The DON stated MA G should have never removed the card from the cart. She stated MA G should have let the nurse know Resident #4 needed a re-order for the Ativan. The DON stated checks and balances included: MA G and LVN H would sign off when all narcotics were administered from a blister pack. They would then remove the empty blister pack and they would give her the narcotic count sheet. The DON stated she would waste the card (empty blister pack) and count sheets were added to the Resident's hard chart and a copy was scanned and uploaded into the Resident's electronic Health Record. The DON stated ultimately, they were not able to determine what happened to the 2 missing Ativan tabs. She stated Resident #4 did not miss any Ativan doses. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Left VM for LVN A on 2/12/25 at 5:10 PM requesting she return the call. She did not return the call before the investigation was completed. Left VM for LVN A on 2/13/25 at 2:13 PM requesting she return the call. She did not return the call before the investigation was completed. Observation and interview on 2/14/25 at 9:17 AM revealed Resident #4 was lying in bed watching TV (volume very loud), eating chips. Resident #4 stated he had lived in the facility for about 2 years. He stated he received his medications regularly and had not missed any medications. Interview on 2/14/25 at 4:34 PM with the ADM revealed she remembered the incident with the two missing Ativan tabs for Resident #4. The ADM stated she interviewed staff involved. She stated MA G pulled the Ativan card blister pack from the cart and took it to LVN A. MA G reported there were 2 tabs left in the card. During interview, LVN A stated when MA G handed her the card, she noted there were no tablets left in it. LVN A reported she noted there were no refills left so she called the doctor for a re-order. LVN A reported she left the empty card at the nurse's station. LVN H, who was scheduled for duty found the card at the nurse's station and it was empty. The ADM stated during interviews all the staff was upset and claimed they did not know what happened to the two tablets. The ADM stated they were not able to determine what happened to the two missing Ativan tablets. The ADM stated nursing staff should not have pulled the Ativan card before administering all the tablets. She stated there were processes in place for this reason, to avoid discrepancies, medication errors or diversion of medications. 2. Review of Resident #5's face sheet, dated 2/14/25, revealed he was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia and Anxiety Disorder. Review of Resident #5's quarterly MDS, dated [DATE], revealed staff was not able to interview him to determine BIMS score; he had a diagnoses of Bipolar and Anxiety and was receiving anti-anxiety medication. Review of Resident #5's Care Plan, revised on 12/16/24 read: he was receiving anti-anxiety medications related to Anxiety. One of the interventions read: Administer ANTI-ANXIETY Ativan medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Review of Resident #5's consolidated physician orders revealed an order: Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth two times a day for ANXIETY. Review of Resident #5's MAR for February 2025 revealed he received Ativan per physician orders. Observation and interview of MA G counting controlled medications on 2/14/25 at 1:10 PM revealed MA G pulled Resident #5's Ativan card. She compared it to the narcotic count sheet and the count was correct. However, there was no signature of the person who administered the medication. MA G stated she administered the Ativan to Resident #5 but she did not sign off when she administered it on 2/14/25 during the 9:00 AM medication pass. MA G stated it was important that she follow processes to prevent discrepancies which could lead to medication errors or diversion of medications. She stated she meant to sign off on it but was distracted and forgot. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/14/25 at 1:16 PM with the DON revealed anytime nursing staff did not follow processes when administering medications it could cause a medication error, discrepancy and or diversion of medications. If given incorrectly it could cause a resident to have a decline in condition. The DON stated it was important to pay attention and for staff to follow the processes per facility policy. Review of facility policy, Medication Administration, dated 10/24/22, read in relevant part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 14. Administer medication as ordered in accordance with manufacturer specifications. 17. Sign MAR after administered. 18. If medication is a controlled substance, sign narcotic book.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency for 1 of 11 Residents (Resident #6) who were reviewed for abuse, in that: The facility did not report an allegation of abuse per facility policy to the State Survey Agency (HHSC) when Resident #6 alleged Resident #7 that provided unwanted sexual favors. This deficient practice could affect any resident and could contribute to further abuse. The findings were: Record review of the facility policy and procedure titled, Abuse, Neglect and Exploitation dated 8/15/22, revealed in part, .Reporting of all alleged violations to the .state agency .within specified timeframe's . 1. Review of Resident #6's face sheet, dated 2/11/25, revealed he was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Recurrent, Moderate and Schizoaffective Disorder, Depressive type. Review of Resident #6's annual MDS assessment, dated 12/6/24, revealed his BIMS score was 3 of 15 reflective of severe cognitive impairment. 2. Review of Resident #7's face sheet, dated 2/11/25, revealed he was admitted to the facility on [DATE] with a diagnosis unspecified Dementia. Review of Resident #7's admission MDS assessment, dated 2/5/25, revealed his BIMS score was 10 of 15 reflective of moderate cognitive impairment. Review of a Provider Investigation Report, dated 2/12/25, revealed an allegation of verbal and physical aggression was investigated. Allegedly, Resident #6 slapped Resident #7 on the leg. Further review revealed Resident #6 stated he did it because Resident #7 crawls over to him in the night and provides sexual favors. Record review of Texas Unified Licensure Information Portal (TULIP) revealed that no self-reported incident regarding allegations of sexual abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/13/25 at 11:30 AM with the DON related to the incident between Resident #6 and Resident #7 revealed both made an allegation. Resident #7 alleged that Resident #6 slapped him on the leg. Resident #6 alleged that Resident #7 would suck his [penis] at night which was not solicited or wanted. The DON stated she did not know if the allegation Resident #6 was reported because the ADM was responsible for reporting allegations of abuse to HHSC; however, she stated to her understanding both were reportable allegations of abuse. Interview on 2/13/25 at 4:34 PM with the ADM revealed she identified during the investigation involving Resident #6 and Resident #7 there were 2 allegations that should have been reported; physical abuse which she reported and sexual abuse which she did not report. The ADM stated she incorporated both allegations into the investigation for physical aggression but should have reported and investigated each allegation separately.

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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** 34957 Based on observation, interview, and record review the facility failed to 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, including a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment, and written standards, policies, and procedures for the program, which must include, but are not limited to: . (ii) When and to whom possible incidents of communicable disease or infections should be reported, for 1 of 1 facility reviewed for infection control, in that: The facility failed to have written standards that include when and to whom possible incidents of communicable disease or infection should be reported. These failures could place residents at risk of a delay in identification of infectious outbreaks and lack of timely follow-up on recommended interventions to prevent harm, or impairment. The findings included: 1. Record review of Resident #2's face sheet, dated 2/11/25 revealed a 94 -year-old female admitted [DATE] with diagnoses that included: UNSPECIFIED DEMENTIA, ENCEPHALOPATHY (enlargement of the brain), UNSPECIFIED MACULAR DEGENERATION (blindness over time), and GLAUCOMA (eye damage). Record review of Resident #2's most recent quarterly MDS assessment, dated 11/13/24 revealed, the resident's BIMS score was zero (severely cognitively impaired) and required limited assistance with mobility and transfers. Record review of Resident #2's Order Summary Report, dated 12/13/24 revealed the following: - Enhanced Barrier Precautions - PPE: Gloves/Gown during high-contact resident care activities every shift with order - Skin Scraping Test one time only to rule out scabies for one day, with order date 12/13/24. -biopsy 12/16/24 one positive for scabies - Ivermectin Oral Tablet 3 MG, give 3 mg tablet by mouth one time only for scabies for 1 day, with order date 12/24/24 and 12/31/24. -permethrin 5% cream two doses 12/20/24 and 12/27/24 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's microbiology report dated 12/16/24 revealed the resident was positive for scabies. Record review of Resident #2's comprehensive care plan dated 12/13/24 revealed the resident had a rash to the torso and was prescribed Triamcinolone Acetonide Cream 0.5 %. 2. Record review of Resident #3's face sheet, dated 2/11/25 revealed a 94 -year-old female admitted to the facility on [DATE] with diagnoses that included: UNSPECIFIED DEMENTIA, RIGHT FEMALE BREAST CANCER, and MAJOR DEPRESSION. Record review of Resident #3's most recent quarterly MDS assessment, dated 12/26/24 revealed, the resident's BIMS score was 3, which indicated she was severely cognitively impaired and required extensive assistance with mobility and transfers. Record review of Resident #3's Order Summary Report, dated 1/3/25 revealed the following: - Enhanced Barrier Precautions - PPE: Gloves/Gown during high-contact resident care activities every shift with order - Skin Scraping Test one time only to rule out scabies for one day, with order date 1/2/25 - permethrin 5% cream two doses 1/3/25 Record review of Resident #3's microbiology report dated 1/2/25 revealed the resident was positive for scabies. Record review of Resident #3's comprehensive care plan dated 1/2/25 revealed the resident had Scabies and was prescribed permethrin 5% cream two doses. During an interview on 2/11/25 at 11:46 AM, the DON (IC Preventionist) stated: the outbreak started with Resident #2 on December 16, 2024, and subsequent infection of Resident #3 was January 2, 2025 (end of scabies outbreak). The DON stated no other resident tested positive. The DON stated the treatment given for Resident #2 on 12/19/24 was permethrin 5 % cream one application neck to toe and second application one week later. DON stated the treatment for Resident #3 was permethrin 5 % cream one application neck to toe. The DON stated the spread was contained by skin assessments for all residents. The DON stated the physician orders were given for prophylactic treatment of Hall 200 and 400. The DON stated all linen in Halls 200 and 400 were removed and replaced and washed, and deep cleaning in every room was conducted by housekeeping. The DON stated that 100% training on infection control and scabies was given to the staff from the time 12/16/24-01/2/25. The DON stated that the RP/family and MD were notified for the residents that tested positive for scabies. The DON stated that scabies was not a reportable event to the local health department. The DON stated that no staff presented with positive scrapings for scabies, but staff could have received prophylactic treatment in the community during the outbreak. The DON stated that the positive residents were placed in isolation. The DON stated that no self-report to HHS was made about the scabies outbreak. The DON stated that the facility did not know the source of the scabies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 4:11 PM, LVN A stated she worked with Resident #3 since the resident was admitted . LVN A stated that the resident had dementia with no behaviors exhibited and nursing care involved medication administration and ADL services. Also, LVN A stated nursing care involved weekly skin assessments and daily observation of skin integrity. LVN A stated scabies was a mite that got under the skin and was contagious and formed skin clusters LVN A stated that Resident #3 had scabies and treatment involved cream and an PO (by mouth) medication. The LVN stated the MD and RP were notified. LVN A stated that HHS should have been notified because scabies was a parasite, and it could spread to other residents and cause an infection. During an interview on 2/12/25 at 8:56 AM, LVN B stated: she did not know the source of the scabies in December 2024 and January 2025. LVN B stated the interventions put in place included: treatment for Resident #2 and Resident #3; handwashing, PPE (contact isolation), and in-service for all staff on scabies. LVN B stated the outbreak ended around 1/3/25. LVN B state preventative measures put in place were continued education on IC for staff and residents, and weekly skin assessments. LVN B stated at the time of the outbreak RPs, MD C, and families were notified of the outbreak; but did not know whether HHS was notified. LVN B stated that Resident #2 had a rash, and MD C was making rounds and assessed the rash and ordered the skin scraping which was negative. The resident had a second appointment with MD C and a procedure (biopsy) which revealed one site (middle back) positive for scabies and the other site was negative (upper middle). Regarding Resident #3, LVN B stated that her family was changing the resident and noticed a few spots on the resident's abdomen area and informed the charge nurse. LVN B stated that Resident #3 was sent out for a medical appointment the same day with MD D and skin scraping was done which revealed a positive result for scabies. LVN B was not sure about reporting requirements to HHS. During an interview on 2/12/25 at 10:08 AM, the Housekeeping Supervisor stated: housekeeping did deep cleaning of halls 200 and 400 in the months of December 2024 and January 2025 because there were cases of scabies. The Housekeeping Supervisor stated that deep cleaning involved: clothing out of closets was washed, curtains and bed linen were washed, and surface cleaning with DC-33 (disinfectant) done in the residents' rooms. During a telephone interview on 2/12/25 at 10:20 AM, MD E stated: there was an outbreak of scabies in the facility that started December 2024 and ended in January 2025. MD E stated the source of the scabies was likely a visitor or a staff member that brought the scabies into the facility. MD E stated that he treated the infected residents (Resident #2 and #3) with permethrin 5% cream and/or Ivermectin Oral Tablet. MD E stated that the facility put in place preventative measures which included: contact precautions, monitoring, and skin assessments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 11:20 AM, the Administrator stated: the timeline of confirmed cases of scabies was 12/19/24 to 1/2/25. The Administrator stated there had been no other confirmed cases based on scrapings after 1/3/25. The Administrator stated that preventative measures included: education, employees to fill out incident reports if they had scabies, IC training, Plan of Correction to capture rash and skin issues, proper IC measures and rooms were cleaned. The Administrator stated that she could not determine the source of the scabies. The Administrator stated that another preventative measure for residents was prophylactic treatment for residents in hall 200 and 400; and the halls were deep cleaned. In December 2024 and January 2025. The Administrator stated that the outbreak was reported to the MD (C), RP, and residents and families. The Administrator stated the outbreak was not reported to the local health department because it was not a reportable event. The Administrator stated the outbreak was not reported to HHS because it was not a self-report, and the source was not known. Observation and interview on 2/11/25 at 4:30 PM, Resident #3 was sitting in a wheelchair in the dining room alert and not oriented. There were no signs of skin tears, bruises, or injury. The resident revealed no signs of itching or a rash. The resident stated that she did not want an interview with the surveyor. Observation and interview on 2/11/25 at 4:40 PM, Resident #2 was in the secured unit. The resident was ambulatory with visual impairment. The Resident had no skin tears, bruises, or injuries present. The resident was not itching or scratching and did not have a rash. The resident stated that she received the care needed and had no complaints about care. The resident stated she could not remember having scabies. The resident stated she was not itching. Record review of the facility's policy and procedure titled, Infection Prevention program dated 5/13/23, revealed in part, This facility has established and maintains 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 as per accepted national standards and guidelines . [Policy did not address reporting communicable diseases to HHSC.]