STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675071	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
YORKTOWN NURSING AND REHABILITATION CENTER	670 W FOURTH ST YORKTOWN, TX 78164

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to notify the ombudsman of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood for 1 of 13 residents (Resident #20) reviewed for Discharge Rights in that; The ombudsmen was not notified in writing of the effective date of transfer or discharge for Resident #20, the reason for the transfer/discharge nor the location to which the resident would be transferred. This failure could affect residents who were transferred or discharged to the hospital and put them at risk of having their discharge rights violated. Findings included: Resident #20's Face Sheet, dated 03/06/2020, revealed the resident was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #20's Discharge Return Anticipated MDS, dated [DATE] and 12/22/2019, revealed the resident discharged from the facility to an acute hospital. Review of Resident #20's Entry MDS, dated [DATE] and 1[DATE]19, revealed the resident re-entered the facility from an acute hospital. Review of Resident #20's medical record revealed no documentation of the ombudsman being notified in writing of the effective date of transfer or discharge for Resident #20, the reason for the transfer/discharge nor the location to which the resident would be transferred. Record review of Resident #20's electronic Census revealed the resident was discharged from the facility from 12/18/19 to 12/21/19 and 12/22/19 to 12/24/19. Record review of Resident #20's Progress Notes revealed: -A General Note, dated 12/18/2019, which documented nurse Called (Resident's Physician) that resident was more lethargic and drowsy this am. That resident denied to eat breakfast this am and that he was very sleepy during his bath this am. cital signs at (blood pressure at) 108/63, pulse at 78, afebrile at (temperature at) 97.6 (and oxygen) saturation at 97% on room air. (Resident's Physician) states to have him sent to ( ) ER for further evaluation. (.) -A General Note, dated 12/18/2019, ( ) emergency medical services here at this time and picked up resident for transport to ( ) hospital emergency room for eval and treat. -A General Note, dated 12/18/2019, which documented called ( ) hospital emergency room to check on resident's status. Spoke with (RN) who stated resident was admitted with [DIAGNOSES REDACTED]. Assisted inside via wheelchair. VSS. Resident returns on [MEDICATION NAME] 500mg PO daily x 7 days and PRN [MEDICATION NAME]. Medications have been ordered. Alert with mild confusion. (Physician) notified of resident returning to facility and of new orders. Resident to be monitored closely for any changes/worsening in condition. (Resident's Physician) to follow up at nursing center. -A General Note, dated 12/22/2019, which documented Resident (with) SOB, appeared to be in respiratory distress. Oxygen saturation at 91% on room air. Resident readmitted to facility with Bilateral Lower Lobe yesterday after a 2 day stay in (the) ICU. (Physician) notified of signs and symptoms and ordered resident to be transferred back to (the Hospital). ( ) Resident (left) facility (at) 630 (am) with EMS. Transfer paperwork and OOH DNR sent with EMS. All orders discontinued as resident was readmitted . -A Clinical Health Status Evaluation Note, dated 1[DATE]19, which documented the resident admitted to facility from (the hospital) with dx of pneumonia. Resident is alert with confusion noted. During an interview on 03/03/20 at 9:17 a.m., the Ombudsman reported the facility had not been sending a monthly list of residents that have been transferred and/or discharged from the facility. During an interview on 03/06/20 at 11:50 a.m. the Administrator reported they have not been notifying the ombudsman regarding resident hospitalization s. The Administrator stated she had contacted the ombudsman and the ombudsman requested that the facility be sending her a monthly email with this information.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the assessment accurately reflected the resident's status for 2 of 13 residents (Resident #27 and #32) whose assessments were reviewed, in that: 1. Resident #27's MDS assessment did not reveal the resident had a fall with a major injury. 2. Resident #32's MDS assessment did not reveal the resident was receiving a therapeutic diet. This deficient practice could affect residents who are at risk for falls and could place them at-risk by contributing to inadequate care based on inaccurate assessments. Findings included: 1. Record review of Resident #27's face sheet, dated 03/06/2020, revealed the resident admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #27's EMR revealed the resident had an Annual MDS completed on 10/10/2019 and a Significant Change MDS on 01/10/2020. Record review of Resident #27's Significant Change MDS, dated [DATE], revealed the resident was coded as having a BIMS score of 5 which means the resident had a severe cognitive impairment. The same MDS also revealed the resident had not had any falls since admission or prior assessment. Record review of the facility's Incident Report for 12/01/19-03/03/20 did not reveal an incident report for Resident #27's fall on 12/08/19. Record review of notes in Resident #27's Progress Notes documented on: - A General Note, dated 1[DATE]19 at 8:15 a.m., revealed Resident found sitting on floor with back against bed. Bright red blood noted to be pooled in front of closet door and what appeared to be blood tracked from shoes all over floor from bed to closet and from closet to hallway door. Blood pressure 168/90, pulse 92, respiration 20. Resident slightly confused and unable to tell staff what happened. Resident noted to have bright red blood all over the back of her shirt that had ran down and saturated her pants and panties. {daughter) notified, (physician) notified and emergency medical services was activated at that time. Resident transported to emergency room for evaluation. (DON) notified of incident. Report call to emergency room . - A General Note, dated 1[DATE]19 at 11:10 a.m., revealed Resident returns with daughter, ( ) via private auto. Ambulating with stand by assist. Pleasantly confused. emergency room gave no orders however did draw lab and resident found to be severely anemic with Hgb 5.9 and wanted to transfuse however resident refused. ( ) During an interview on 03/06/20 at 12:43 p.m., RN C revealed she was the nurse who wrote the general note on Resident #27's fall on 12/08/19. RN C confirmed they found the resident on the floor with blood on the floor. RN C revealed they were sure where the blood was coming from because she had some wounds on her back that could have been releasing the blood, but they sent the resident to the hospital and there were no new orders. During an interview on 03/06/20 at 12:57 p.m., the DON confirmed Resident #27 had a fall on 12/08/19 and she was sent out to the hospital. During an interview on 3/06/20 at 11:13 a.m., the RN Assessment Coordinator (RNAC) reported she was not aware Resident #27 had a fall on 12/08/19, but she would look through the resident's record to confirm. The RNAC confirmed Resident #27's Significant Change MDS did not indicate the resident had a fall with injury. The RNAC confirmed Resident #27's last two MDSs were completed on 10/10/19 and 01/10/20. During an interview on 03/06/20 at 11:22 a.m., the RNAC confirmed Resident #27's progress notes indicated she had a fall on 12/8/19. The RNAC also confirmed the Significant Change MDS was incorrect and needed to be corrected to indicate the resident had a fall with injury. Record review of the CMS's RAI Version 3.0 Manual, dated October 2019, revealed in the Definition section revealed Falls (was defined as the) unintentional change in position coming to rest on the ground, floor or onto the next lower surface. 2. Record review of Resident #32's face sheet, dated 03/06/2020,

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

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.

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #32's Quarterly MDS, dated [DATE], revealed the resident was coded as having a BIMS score of 10 means the resident had a moderate cognitive impairment. The same MDS also revealed the resident received a mechanically altered and feeding tube nutritional approaches, but the nutritional approach of a therapeutic diet was not indicated. Record review of Resident #32's Care Plan, undated, revealed a focus of Nutrition: The resident [MEDICAL CONDITION]/t gastrotomy status, history of cerebral infarction, with an interventions of no added salt diet, mechanical soft texture and to follow orders for gastrostomy tube, feedings and treatments. Report and changes or concerns. May hold feeding for complaints of GERD. Record review of Resident #32's Active Physician Orders, dated 03/06/2020, revealed orders for: - No Added Salt diet, Mechanical Soft texture with an order date of 6/28/19 and no end date. - Enteral Feed one time a day [MEDICATION NAME] 1.2 cal. Give 46ml/hr for 5 hours from 8PM until 0100 AM, with an order date of 01/20/2020 and no end date. Record review of Resident #32's Dietary Notes, dated 12/4/2019, revealed the resident was on a no added salt, mechanical soft diet; in addition to receiving enteral feedings of [MEDICATION NAME] 1.2 @ 55ml/hr x 8 hours overnight which provides 528kcal daily. Goal has been to eventually wean resident off enteral feedings. (.) During an interview on 03/06/20 at 10:33 a.m., the RNAC confirmed Resident #32's Quarterly MDS did not indicate the resident was receiving a therapeutic diet. The RNAC also confirmed Resident #27 had an order for [REDACTED].#27's Quarterly MDS need to be corrected to indicate the resident was also receiving a therapeutic, mechanically altered and feeding tube diet. Record review of the CMS's RAI Version 3.0 Manual, dated October 2019, in the Nutritional Approaches section revealed a therapeutic diet examples included a low salt, diabetic, and low cholesterol diet.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident with pressure injuries receives the necessary treatment and services, consistent with professional standards of practice, to promote healing of pressure injuries for 1 of 2 residents (Resident #20) reviewed for risk of pressure injuries. The facility failed to ensure Resident #20's pressure reducing mattress was set on the correct setting. This failure could place residents with pressure ulcers who had pressure reducing mattress at risk for new development of pressure injuries or worsening of existing pressure injuries. Findings included: Resident #20's Face Sheet, dated 03/06/2020, revealed the resident was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #20's Significant Change MDS, dated [DATE], revealed the resident had a Cognitive Skills for Daily Decision-Making score of 2 which indicated the resident was moderately impaired. The record also documented the resident was at risk of developing a pressure ulcer, but he did not have a current pressure ulcer. The record also indicated the resident used a pressure relieving device for the bed. Record review of Resident 20's Care Plan, undated, documented intervention for the resident focus of hospice that a low air loss mattress (be) on at all times (and to) check function of air mattress 2 times a day every day and night shift. Record review of Resident #20's EMR Active Orders, dated 3/05/2020, revealed an order for [REDACTED]. every day and night shift for pressure relief, with a start date of 1/06/2020 and no end date. During an observation on 03/03/20 at 10:16 a.m. in Resident #20's room revealed the resident was not in the room but his pressure reducing mattress was on and set for a weight of 280 lbs, per the scale on the machine. During an observation on 03/05/20 at 4:26 p.m. in Resident #20's room revealed the resident was not in the room but his pressure reducing mattress was on and set for a weight of 280 lbs, per the scale on the machine. During an interview on 03/05/20 at 4:26 p.m. in Resident #20's room, the Health Information Management Coordinator confirmed Resident #20's pressure reducing mattress was on and set for a weight of 280 lbs. The Health Information Management Coordinator also confirmed Resident #20's weight was currently at 179 lbs. The Health Information Management Coordinator revealed Resident #20 did not have any pressure ulcers. The Health Information Management Coordinator revealed the air mattress was provided by hospice so she was going to call them to see how they wanted it set. During an interview on 03/05/20 at 4:31 p.m., with the Health Information Management Coordinator and LVN B, revealed LVN B that they were supposed to check the functioning of Resident #20's air mattress daily. LVN B also revealed Resident #20's air mattress was working but she was not aware that it was set for a weight of 280 lbs. The Health Information Management Coordinator revealed the hospice company stated Resident #20 air mattress could be set at any pressure to meet his comfort level. The Health Information Management Coordinator asked LVN B if Resident #20 had complained to her about his bed being uncomfortable. Record review of the User Manual for the Med-Aire Assure 5 Air + 3 Foam Base Alternating Pressure and Low Air Loss Mattress System Item # , dated 2014, revealed Operation Instruction of 9. Turn the Pressure Adjust Knob to set a comfortable pressure level using the weight scale as a guide. During an interview on 03/06/20 at 1:20 p.m. the DON revealed Resident #20's hospice company reported they could set the resident pressure level on his air mattress to meet his comfort level. The DON also confirmed she reviewed the air mattress manufacture's instructions which indicated to use the resident's weight as a guide.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to assure drugs and biologicals were secured properly for 1 of 3 medication carts reviewed, in that: Station # 1 Medication Cart held expired medical supplies and stored chemicals with food and drink items. These deficient practices could place residents who received medications at-risk for not receiving the intended therapeutic benefit of their medications as ordered. The findings were: Observation on [DATE] at 11:24 AM, during review of Station # 1 Medication Cart revealed a culture swab collection and transport system for aerobes and anaerobes with an expiration date [DATE] stored in the medication cart top drawer. Further review of Station # 1 Medication Cart revealed an open container of bleach wipes stored in bottom drawer with one 32 fluid ounce Med Pass High Calorie, High Protein Nutritional Drink, six 3.5-ounce Grab n Snack Vanilla Puddings, four 4 ounce thickened Lemon Flavored Water and one 8 ounce can of Thick and Easy instant food and beverage thickening powder. During an interview on [DATE] at 11:26 AM, LVN A confirmed the expired culture swab and a container of bleach wipes were stored with resident food and drinks in the medication cart. LVN A further stated she was unsure why the culture swab was in the medication cart and should not have been there. She also stated food and cleaning disinfectant should not be stored together. During an interview on [DATE] at 11:38 AM with the DON she stated expired medical supplies should not be stored in medication carts and bleach wipes are to be stored separate from food items. During an interview on [DATE] at 11:57 AM with the DON she stated the facility did not have a policy on medication cart storage.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 2 meals (lunch) reviewed, in that: The facility did not puree the turkey with gravy to pudding or mashed potato consistency as required for food served to residents who received a pureed diet. This deficient practice could affect residents who received pureed meals from the kitchen by contributing to dissatisfaction, poor intake, and/or weight loss. The findings included: Record review of Resident #19's face sheet, dated 03/06/2020, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #19's Admission MDS, dated [DATE], revealed the resident had a Cognitive Skills for Daily Decision-Making score of 2 which indicated the resident was moderately impaired. Record review of Resident #19's Care Plan, dated revision on 03/02/2020, revealed a focus of Diet: Resident will have a regular puree texture meal with nectar thickened liquids. Record review of Resident #19's Active Orders revealed the resident had and active order for a regular puree diet with nectar thickened liquids. Record review of the facility Diet Roster, dated 3/03/2020, revealed Resident #20 was to receive a regular puree diet with nectar thickened liquids. Record review of the facility's Diet Spread Sheet for Day 4 of Week 1 revealed for lunch the residents on a puree diet were to receive puree roast turkey with gravy, mashed potatoes, pureed broccoli, puree mixed

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F 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) fruit cup and a puree dinner roll. Observation on 03/05/2020 at 11:53 a.m., Resident #19 was served the lunch meal with pureed turkey with gravy that had chunks and lumps in it. During an interview on 03/05/2020 at 11:53 a.m., the surveyor reported to the DON Resident #19's turkey and gravy looked lumpy. The DON then took Resident #19's plate back into the kitchen. Observation on 03/05/2020 at 11:56 a.m., LVN B brought Resident #19 a new lunch tray out. During an interview on 03/05/2020 at 11:59 a.m., the Dietary Manager confirmed Resident #19's pureed turkey with gravy had lumps and was not smooth so they put it back through the blender to make it [MEDICATION NAME] for the resident. Record review of the facility's Dietary Manual revealed a Puree Basic Facts Sheet, undated, which indicated the puree diets are residents who cannot chew food or swallow without difficulty. Food is blended to a mash potato or applesauce consistence and requires no chewing before they are swallowed.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to maintain medical records that were accurately documented for 1 of 12 residents (Resident #27) whose medical records were reviewed in that: The facility failed to complete an incident report for Resident #27's fall with injury. This deficient practice could affect residents at risk for falls in the facility and result in the residents not attaining the highest practicable well-being. The findings were: Record review of Resident #27's face sheet, dated 03/06/2020, revealed the resident admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #27's EMR revealed the resident had an Annual MDS completed on 10/10/2019 and a Significant Change MDS on 01/10/2020. Record review of Resident #27's Significant Change MDS, dated [DATE], revealed the resident was coded as having a BIMS score of 5 which means the resident had a severe cognitive impairment. The same MDS also revealed the resident had not had any falls since admission or prior assessment. Record review of the facility's Incident Report for 12/01/19-03/03/20 did not reveal an incident report for Resident #27's fall on 12/08/19. Record review of notes in Resident #27's Progress Notes documented on: - A General Note, dated 1[DATE]19 at 8:15 a.m., revealed Resident found sitting on floor with back against bed. Bright red blood noted to be pooled in front of closet door and what appeared to be blood tracked from shoes all over floor from bed to closet and from closet to hallway door. Blood pressure 168/90, pulse 92, respiration 20. Resident slightly confused and unable to tell staff what happened. Resident noted to have bright red blood all over the back of her shirt that had ran down and saturated her pants and panties. {daughter) notified, (physician) notified and emergency medical services was activated at that time. Resident transported to emergency room for evaluation. (DON) notified of incident. Report call to emergency room . - A General Note, dated 1[DATE]19 at 11:10 a.m., revealed Resident returns with daughter, ( ) via private auto. Ambulating with stand by assist. Pleasantly confused. emergency room gave no orders however did draw lab and resident found to be severely anemic with Hgb 5.9 and wanted to transfuse however resident refused. ( ) During an interview on 03/06/20 at 12:43 p.m., RN C revealed she was the nurse who wrote the general note on Resident #27's fall on 12/08/19. RN C confirmed they found the resident on the floor with blood on the floor. RN C revealed they were sure where the blood was coming from because she had some wounds on her back that could have been releasing the blood, but they sent the resident to the hospital and there were no new orders. During an interview on 03/06/20 at 12:57 p.m., the DON confirmed Resident #27 had a fall on 12/08/19 and she was sent out to the hospital. The DON also confirmed the facility did not complete an incident report the resident's fall when they should have. During an interview on 03/06/20 at 1:20 p.m., the DON reported the facility did not have a policy on incidents and accidents reports, but stated that they should be completed after every incident.