

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 11/18/2025
NAME OF PROVIDER OR SUPPLIER Yoakum Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as those which had not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay for 1 of 3 residents (Resident #1) reviewed for having their grievances heard. LVN A failed to generate a grievance report for Resident #1's Representative's grievance made on 10/20/2025 when Resident #1's representative complained that Resident #1 had blood on his linens as observed through a bedroom camera. LVN A failed to generate a grievance report for Resident #1's Representative's grievance made on 10/25/2025 at 6:05 AM when Resident #1's Representative complained that Resident #1 did not have the use of a bedside table. These failures could place residents at risk for demoralized spirits and low self-esteem. The findings included: A record review of Resident #1's admission record dated 11/4/2025 revealed an admission date of 4/11/2025 and a discharge date of 11/1/2025; with diagnoses which included dementia (a general term for a decline in cognitive function, affecting memory, thinking, and social abilities to the extent that it interferes with daily life.). review revealed Resident #1 was a [AGE] year-old male admitted for long term care with ADL needs for dementia. A record review of Resident #1's care plan dated 11/4/2025 revealed, (Resident #1) has an ADL self-care performance deficit related to dementia . Resident requires substantial / maximal assistance for personal hygiene. A record review of Resident #1's physicians orders dated 7/5/2025 revealed the physician ordered for Resident to receive care related to his indwelling urinary catheter twice a day and as needed. A record review of Resident #1's medication administration record for October 2025 revealed LVN A documented she provided urinary indwelling Catheter care on the evening of 10/20/2025. A record review of Resident #1's nursing progress notes dated 10/25/2025 at 6:05 AM, revealed LVN A documented, Note Text: resident's (representative) called upset wanting to know why did his bedside table get taken out of his room. wanted to know if we had put him off to eat on his own, I explained to her that her (resident #1) had eaten in the dining room that it was being borrowed it was not used for him.[sic] During an interview on 11/4/2025 at 11:00 AM Resident #1's Representative stated she was unsatisfied with the care provided for Resident #1. Resident #1's Representative stated she had made many grievances to the facility regarding Resident #1's care and gave 2 examples:1. On October 20th, 2025, she reviewed the evening video footage captured by the bedroom camera which revealed at 7:02 PM LVN A entered Resident #1's room and discovered Resident #1 was seated on his bedside. LVN A redirected Resident #1 back to bed and covered him with blankets. Resident #1's Representative stated she observed some blood to Resident #1's linens and blankets. Resident #1's Representative stated she called the facility sometime that evening approximately around 10:00 PM and spoke to LVN A and inquired about Resident #1's bleeding and complained about LVN A's care, specific for urinary indwelling catheter.2. Resident #1's Representative stated on 10/25/2025 at 6:00 AM she called the facility and spoke to LVN A and complained that Resident #1's bedside table was not at the bedside as observed with the in-room camera.Resident #1's Representative stated her grievances were not resolved.During an interview on 11/4/2025 at 5:50 PM LVN A stated she was a nurse for the facility and usually worked the 6:00 PM to 6:00 AM shift and had cared for Resident #1. LVN A stated Resident #1 was a [AGE] year-old male under hospice and facility care. LVN A stated Resident #1 had a need for a urinary indwelling catheter related to his enlarged prostate urinary retention. LVN A stated she was familiar with Resident #1's Representative who had a camera in the resident's bedroom and often made complaints. LVN A stated she recalled sometime late last month, October 2025, Resident #1's representative called the facility late in the evening and complained she had reviewed the camera footage and saw some blood on the bed linens. LVN A stated she had rounded on Resident #1's several times that evening and redirected him back to bed when she would find him sitting on his bedside. LVN A stated Resident #1 had a history of tugging / pulling on his urinary indwelling catheter and had caused some bleeding. LVN A stated she had assessed Resident #1 without any bleeding to the urinary indwelling catheter and redirected him back to bed. LVN A stated Resident #1's Representative called the morning of 10/25/2025 and spoke with her to complain that Resident #1 was not in his room, and neither was his bedside table. LVN A speculated Resident #1's Representative believed Resident #1 was put aside and not cared for. LVN A stated she reported to</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records on each resident that were complete; accurately documented; readily accessible; and systematically organized for 1 of 3 residents (Resident #1) reviewed for reviewed for accurate records. LVN A and LVN B failed to document the failed attempts to instill a urinary indwelling catheter for Resident #1 and the report to the physician. These failures could place residents at risk for diminished health status. The findings included: A record review of Resident #1's admission record dated 11/4/2025 revealed an admission date of 4/11/2025 and a discharge date of 11/1/2025; with diagnoses which included dementia (a general term for a decline in cognitive function, affecting memory, thinking, and social abilities to the extent that it interferes with daily life). Further review revealed Resident #1 was a [AGE] year-old male admitted for long term care with ADL needs for dementia. A record review of Resident #1's care plan dated 11/4/2025 revealed, (Resident #1) has an ADL self-care performance deficit related to dementia . Resident requires substantial / maximal assistance for personal hygiene. A record review of Resident #1's physicians orders dated 7/5/2025 revealed the physician ordered for Resident to receive care related to his indwelling urinary catheter twice a day and as needed. A record review of Resident #1's physicians orders dated 9/11/2025, revealed, the physician ordered Resident #1 to have a urinary indwelling catheter to support his urinary retention complicated by an enlarged prostate; Foley Catheter: Change 22F with 30ml bulb q month every night shift starting on the 11th and ending on the 11th every month. A record review of Resident #1's medication administration record for October 2025 revealed LVN A documented she instilled Resident #1's urinary indwelling catheter on 11/11/2025. A record review of Resident #1's medical record for the review period of 11/10/2025 through 10/13/2025 revealed no documentation to detail Resident #1's indwelling urinary catheter, nor his change of condition or report to the physician of the change in condition. A record review of Resident #1's nursing progress notes dated 10/12/2025 revealed LVN B at 8:17 AM documented, Note Text: Resident noted with copious amounts of blood clots following having his foley catheter replace 3 hours prior. Dr. (name) on call called for Dr. (name), no answer awaiting response.[sic] During an interview on 11/4/2025 at 11:00 AM Resident #1's Representative stated she was unsatisfied with the care provided for Resident #1. Resident #1's Representative stated Resident #1 was hospitalized on [DATE] for bleeding related to his indwelling urinary catheter. Resident #1's Representative stated she learned from LVN B that attempts to change Resident #1's indwelling urinary catheter were unsuccessful, and the physician ordered for Resident #1 to be hospitalized for evaluation and treatment. During an interview on 11/4/2025 at 5:50 PM LVN A stated she was a nurse for the facility and usually worked the 6:00 PM to 6:00 AM shift and had cared for Resident #1. LVN A stated Resident #1 was a [AGE] year-old male under hospice and facility care. LVN A stated Resident #1 had a need for a urinary indwelling catheter related to his enlarged prostate urinary retention. LVN A stated Resident #1 had a history of tugging / pulling on his urinary indwelling catheter and had caused some bleeding. LVN A stated Resident #1's physician had ordered for Resident #1 to have his Indwelling urinary catheter changed once a month beginning on 10/11/2025 during the evening shift. LVN A stated she worked that evening and decided to change the catheter the morning of 10/12/2025 around 5 AM in order to have another nurse available if she had complications. LVN A stated when she attempted to instill the new catheter she met with resistance and had no urine return flow and had reported the finding to the next nurse, LVN B. LVN A stated she had not documented the details of the procedure and stated she believed signing the medication administration record was sufficient. LVN A stated she had not documented the nurse-to-nurse report either. During an interview on 11/4/2025 at 6:00 PM LVN B stated she was an LVN at the facility and usually worked 6 AM to 6 PM and recalled she received a report from LVN A on the morning of 10/12/2025 where LVN A had a difficult procedure of instilling an indwelling foley catheter for Resident #1 and had received a report from a CNA that Resident #1 had bleeding evidence in his adult brief. LVN B stated she and LVN A assessed Resident #1 with no return urine flow and LVN B re-attempted to instill a fresh indwelling urinary catheter with no success. LVN B stated she could not overcome Resident #1's enlarged prostate to reach the bladder evidenced by no urine return flow. LVN B stated she reported the findings to the physician and received new orders for Resident #1 to be transferred to the hospital for evaluation and treatment. LVN B stated she believed she had documented the details of the incident and upon record review stated she had not documented details to accurately document the chain of events</p>		