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	05/29/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 1 of 5 residents (Resident #1) observed for call light placement. The facility failed to ensure Resident #1's call light was within reach. This deficient practice could place residents at risk for decreased ability to contact staff for assistance. The findings included: Record review of Resident #1's electronic face sheet dated 05/29/26 reflected a [AGE] year-old male admitted on [DATE]. His diagnoses included: normal pressure hydrocephalus (brain disorder in which excess cerebrospinal fluid accumulates in the brain's ventricles, causing thinking and reasoning problems and difficulty walking), bipolar disorder (condition that causes extreme mood swings) and schizoaffective disorder (mental health condition, marked by a mix of symptoms such as hallucinations and delusions). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood. He scored 9 of 15 on his BIMS which signified his cognitive status was moderately impaired. He required moderate assistance with ADLs. He used a walker for mobility. Record review of Resident #1's FRA dated 05/19/2026 reflected he was high risk for falls. Record review of Resident #1's comprehensive care plan dated 03/11/2026 reflected Focus, is at risk for falls r/t Normal Pressure Hydrocephalus, unsteady gait, use of w/c for mobility, history of falls, be sure the resident's call light is within reach. Observation on 05/29/2026 at 10:30 am accompanied by the ADON, Resident #1 was on the male secured unit. He was sitting in a chair across the room from his bed near the window, his call light was hooked on the room divider curtain approximately 6 feet away, and his walker was in front of him. During an interview on 05/29/2026 at 12:40 pm, Resident #1 stated he would have to cross the room to get his call light if he needed help. He stated he would use the call light if it were located near him. He stated he had not used a wheelchair since he was admitted and always ambulated with a walker. During an interview on 05/29/2026 at 1:13 pm, CNA A, who tended to Resident #1 stated she did not realize his call light was not within reach and missed it. She stated Resident #1 never had a wheelchair and always used a walker. During an interview on 05/29/2026 at 1:20 pm, MA B, who administered medications for Resident #1 on the male secured unit stated she saw him up in a chair but did not think about the call light not being near him. She stated he needed to reach the call light to call for help. During an interview on 05/29/2026 at 1:34 pm, the ADON stated she did not think about putting the call light within Resident #1's reach when she was there earlier. She stated he had fallen previously and it was important to have his call light within reach so he could call for assistance. During an interview on 05/29/2026 at 1:43 pm, the DON stated Resident #1's call light needed to be within his reach, so he could call for help and not fall if he transferred himself. Record review of the facility policy and procedure titled Call Lights: Accessibility and Timely Response dated 10/13/2022 reflected Staff will ensure the call light is within reach of resident and secured, as needed.

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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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 assessments accurately reflected the status of the residents for 1of 5 residents (Residents #1) reviewed for resident assessments. The Facility failed to ensure Resident #1's fall on 04/15/2026 was reflected on his quarterly MDS assessment dated [DATE]. This deficient practice could place residents at risk of missed or inaccurate care. The findings included: Record review of Resident #1's electronic face sheet dated 05/29/26 reflected a [AGE] year-old male admitted on [DATE]. His diagnoses included: normal pressure hydrocephalus (brain disorder in which excess cerebrospinal fluid accumulates in the brain's ventricles, causing thinking and reasoning problems and difficulty walking), bipolar disorder (condition that causes extreme mood swings) and schizoaffective disorder (mental health condition, marked by a mix of symptoms such as hallucinations and delusions). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood. He scored 9 of 15 on his BIMS which signified his cognitive status was moderately impaired. He required moderate assistance with ADLs. He was not coded to have any falls since admission/entry or reentry or prior assessment, whichever was more recent. He used a walker for mobility. Record review of Resident #1's FRA dated 05/19/2026 reflected he was high risk for falls. Record review of Resident #1's comprehensive care plan dated 03/11/2026 reflected Focus, is at risk for falls r/t Normal Pressure Hydrocephalus, unsteady gait, use of w/c for mobility, history of falls, be sure the resident's call light is within reach. Observation on 05/29/2026 at 10:30 am accompanied by the ADON, Resident #1 was on the male secure unit. He was sitting in a chair across the room from his bed near the window. During an interview on 05/29/2026 at 12:40 pm, Resident #1 stated he had fallen in April. During an interview on 05/29/2026 at 12:45 pm, the MDS nurse stated she did not know how she missed reflecting Resident f#1's fall on his quarterly MDS assessment dated [DATE], but she did. She stated the MDS needed to be accurate to reflect the residents and their care requirements or care could be missed. She stated the facility did not have a separate policy that addressed MDS accuracy and she followed the RAI manual. During an interview on 05/29/2026 at 1:43 pm, the DON stated Resident #1 had fallen in April and May, but she could not provide the incident reports because they were part of their QA program. She stated the importance of MDS accuracy was that the care required based on an accurate picture of the resident, and care could be missed. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, dated October 2025 reflected The RAI process has multiple regulatory requirements. Federal regulation required the assessment accurately reflects the resident's status.

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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** Based on observation, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment for 1 resident of 5 residents (Resident #1) reviewed for care plans. The facility failed to implement Resident #1's intervention of keeping his call light within reach, and reflected he required a w/c on his fall care plan instead of a walker. These deficient practices could place residents at risk for missed or inaccurate care.The findings included: Record review of Resident #1's electronic face sheet dated 05/29/26 reflected a [AGE] year-old male admitted on [DATE]. His diagnoses included: normal pressure hydrocephalus (brain disorder in which excess cerebrospinal fluid accumulates in the brain's ventricles, causing thinking and reasoning problems and difficulty walking), bipolar disorder (condition that causes extreme mood swings) and schizoaffective disorder (mental health condition, marked by a mix of symptoms such as hallucinations and delusions). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood. He scored 9 of 15 on his BIMS which signified his cognitive status was moderately impaired. He required moderate assistance with ADLs. He used a walker for mobility. Record review of Resident #1's FRA dated 05/19/2026 reflected he was high risk for falls. Record review of Resident #1's comprehensive care plan dated 03/11/2026 reflected Focus, is at risk for falls r/t Normal Pressure Hydrocephalus, unsteady gait, use of w/c for mobility, history of falls, be sure the resident's call light is within reach. Observation on 05/29/2026 at 10:30 am accompanied by the ADON, Resident #1 was on the male secured unit. He was sitting in a chair across the room from his bed near the window, his call light was hooked on the room divider curtain approximately 6 feet away, and his walker was in front of him. During an interview on 05/29/2026 at 12:40 pm, Resident #1 stated he would have to cross the room to get his call light if he needed help. He stated he would use the call light if it were located near him. He stated he had not used a wheelchair since he was admitted and always ambulated with a walker. During an interview on 05/29/2026 at 12:45 pm, the MDS nurse stated she did not know how Resident #1's care plan reflected w/c under his fall area when he used a walker. She stated the importance of the care plan was, it provided information for the aides on what the residents needed and care could be missed. During an interview on 05/29/2026 at 1:13 pm, CNA A, who tended to Resident #1 stated she did not realize his call light was not within reach and missed it. She stated Resident #1 never had a wheelchair and always used a walker. During an interview on 05/29/2026 at 1:20 pm, MA B, who administered medications for Resident #1 on the male secured unit stated she saw him up in a chair but did not think about the call light not being near him. She stated he needed to reach the call light to call for help. During an interview on 05/29/2026 at 1:34 pm, the ADON stated she did not think about putting the call light within Resident #1's reach when she was there earlier. She stated he had fallen previously and it was important to have his call light within reach so he could call for assistance. During an interview on 05/29/2026 at 1:43 pm, the DON stated Resident #1's call light needed to be within his reach, so he could call for help and not fall if he transferred himself. She stated the care plan intervention was not implemented. She stated he used a rollator and has not used a wheelchair. Record review of the facility policy and procedure titled Comprehensive Care Plans dated 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 objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.