STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455608	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hacienda Oaks at Beeville	4713 Business 181 N Beeville, TX 78102

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a baseline care plan, which included the instructions for resident care needed to provide effective and person-centered care, was completed for 1 of 5 residents (Resident #1) reviewed for baseline care plans. The facility did not complete the baseline care plan within 48 hours of admission to include the minimum healthcare information necessary to properly care for Resident #1. This failure could place residents at risk of not receiving person-centered care and/or services to meet their physical and/or psychosocial needs.Findings included: Record review of Resident #1's face sheet, dated [DATE], revealed she was a [AGE] year-old female admitted on [DATE] and discharged on [DATE]. Pertinent diagnoses included Hemiplegia (paralysis affecting only one side of the body) and Hemiparesis (one sided muscle weakness) following Cerebral Infarction (the most common form of stroke) Affecting Left Non-Dominant Side, Chronic Viral Hepatitis C (liver disease caused by a viral infection), Type 2 Diabetes (a chronic condition which affects the way your body processes blood sugar), and Dysphagia (difficulty swallowing). Resident #1's face sheet also revealed Hospice Respite as the primary payer source. Record review of Resident #1's physician orders, dated [DATE], revealed an order for Do Not Resuscitate. Record review of Resident #1's baseline care plan, initiated [DATE], revealed there was no care plan for hospice or DNR code status. Record review of Resident #1's MDS discharge assessment dated [DATE] revealed no BIMS score, as Resident #1 was rarely or never understood. The MDS also revealed Resident #1 was admitted from home hospice, as well as discharged to home hospice, and Resident #1 received hospice care while in the facility. In an interview on [DATE] at 11:35 AM, the ADON stated both hospice and DNR status should have been listed in Resident #1's care plan, and usually the SS nurse or MDS coordinator added this information to the care plan. The ADON also stated Resident #1 was only there for 5 days, so she would not have had a comprehensive care plan, but the information still should have been entered into the baseline care plan since Resident #1 was here for hospice respite care (short term care which gives caregivers a break from caring for a terminally ill loved one). She stated the code status was important to have on the care plan, so staff knew whether or not to perform CPR on a resident. In an interview on [DATE] at 1:24 PM, the DON stated she thought the hospice and DNR status on the care plan for Resident #1 may have been overlooked since she was only here for a 5-day respite stay. She stated Resident #1 continued to get hospice care while in the facility. The DON also stated it looked like someone just forgot to add hospice to Resident #1's orders, which may have contributed to hospice getting missed on the care plan, but DNR should not have been missed, and should have been added to Resident #1's care plan. The DON stated when there was a hospice respite admission, a coordination of care meeting was done at this time with the hospice case worker and the family, and the baseline care plan was completed based on this, and the MDS coordinator and SS nurse were ultimately responsible for this, but the previous MDS nurse was no longer here. The DON stated if the care plans were not updated with accurate or appropriate information, residents may not get the care they need. In an interview on [DATE] at 2:36 PM, the SS nurse stated she visited new admission residents and performed their BIMS and psychosocial assessments, and she typically inputted the code status and hospice status into the care plan, but then it was typically checked by either the MDS nurse, the DON, or the ADON. She stated she was not sure how or why both hospice and DNR status were overlooked on Resident #1's care plan. The SS nurse stated the care plan was used to tell a story about the resident and guide the resident's care. The care plan helped staff familiarize themselves with the resident and what type of care to the resident needed. She also stated without the code and/or hospice status the resident could have been revived when they were not supposed to be, or not received CPR when they were supposed to. Either way, it could have brought harm to the resident. In an interview on [DATE] at 8:41 AM, the MDS coordinator stated she was initially responsible for inputting hospice and code status, and once the care plan information was entered into the care plan, it was typically checked by the DON or the ADON. She stated both hospice and code status should have been care planned into Resident #1's care plan, and these were important things to have in the care plan so staff were aware of the type of care a resident would have needed and whether a resident should or should not have CPR. Record review of the facility's Baseline Care Plan policy, implemented [DATE] and revised [DATE], revealed The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care

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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 interview and record review the facility failed to ensure the comprehensive care plan was developed and implemented for each resident consistent with resident rights to include measurable objectives and timeframes to meet residents medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 1 of 5 residents (Resident #3) reviewed for care plans. The facility failed to add the diagnosis, or anything related to the diagnosis, of Dementia to Resident #3's care plan. This failure could place residents at risk for receiving inadequate care and services.Findings included: Record review of Resident #3's face sheet dated 09/17/2025 revealed an [AGE] year-old female with an admission date of 10/11/2017 and a re-admission date of 08/27/2025. Pertinent diagnoses included Hemiplegia (paralysis affecting only one side of the body) and Hemiparesis (one sided muscle weakness) following Cerebral Infarction (the most common form of stroke) Affecting Right Dominant Side and Unspecified Dementia (a group of thinking and social symptoms which interfere with daily functioning). Record review of Resident #3's diagnoses dated 08/27/2025 revealed Unspecified Dementia was listed as a secondary admission diagnosis. Record review of Resident #3's admission MDS assessment dated [DATE] revealed a BIMS score of 00, severely impaired cognition. The MDS also revealed Resident #3 had an active diagnosis of Non-Alzheimer's Dementia. The Care Area Assessment portion of the MDS revealed Resident #3 triggered for Cognitive Loss/Dementia, and for each triggered care area, either a new care plan, a revised care plan, or a continuation of a current care plan was necessary to address the problems identified. Record review of Resident #3's care plan initiated 08/28/2025 revealed no care plan focus for Dementia. In an interview on 09/16/2025 at 11:35 AM, the ADON stated usually the MDS coordinator added residents' clinical information to the care plan. The ADON also stated Resident #3 had a diagnosis of Dementia, so it should have been added to Resident #3's care plan, and if the care plans were not up to date, residents may not receive adequate care. In an interview on 09/17/2025 at 8:41 AM, the MDS coordinator stated she was responsible performing the MDS and Care Area assessments and adding those triggers to residents' care plans. She also stated the ADON, and the DON were responsible for reviewing and revising the clinical portions of the residents' care plans. She stated Resident #3 had a diagnosis of Dementia, and it triggered on the Care Area Assessment, so it should have been added to Resident #3's care plan so as to provide the resident with the appropriate needed care. In an interview on 09/17/2025 at 10:44 AM, the DON stated the MDS coordinator was initially responsible for the clinical aspect of the care plans, but either herself or the ADON would be the one to look back and review the care plan was completed accurately. Then, the IDT reviewed and revised them quarterly and with changes in condition. The DON stated the clinical staff, to include herself, the ADON, and the MDS nurse, were ultimately responsible for reviewing and revising the clinical care plans. The DON also stated Resident #3's diagnosis of Dementia should have been care planned, and if the care plans were not updated with accurate or appropriate information, residents may not get the care they need. Record review of the facility's Comprehensive Care Plans policy, implemented 06/01/2025 and revised 06/02/2025, revealed 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 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas triggered by the MDS will be considered in developing the plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 5 residents (Resident #2) whose care plans were reviewed for timing and revision. The facility failed to ensure Resident #2's care plan was revised to accurately reflect current blood pressure medication status. This deficient practice could place residents at risk of receiving inadequate, individualized care and services. Findings included: Record review of Resident #2's face sheet dated 09/17/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Pertinent diagnoses included Unspecified Dementia (a group of thinking and social symptoms which interfere with daily functioning) and Hypertensive Chronic Kidney Disease (a progressive condition in which high blood pressure causes damage to the kidneys). Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 02, severely impaired cognition. The MDS assessment also revealed Resident #2 had Hypertension, as well as Renal Insufficiency, Renal Failure, or End-Stage Renal Disease. Record review of Resident #2's comprehensive care plan, initiated 01/17/2024 and revised 07/18/2024, revealed a care plan for potential for complications related to blood pressure medication use. Record review of Resident #2's current active physician orders revealed no order for blood pressure medications. Record review of Resident #2's inactive physician orders which were discontinued 10/03/2024 revealed an order for Lisinopril (a medication used to treat high blood pressure) 10 MG daily for elevated blood pressure. In an interview on 09/16/2025 at 11:35 AM, the ADON stated the IDT reviewed and discussed the care plans at the quarterly care plan meetings and with changes in condition, but usually the MDS coordinator, herself or the DON added or revised the clinical aspect of information in the care plan. The ADON stated she was not sure why this was never removed from the care plan because Resident #2 was no longer on blood pressure medications. In an interview on 09/17/2025 at 8:41 AM, the MDS nurse stated in conjunction with the ADON and the DON, she was responsible for reviewing and revising the clinical portions of the residents' care plans. She stated she had not worked here long and had been trying to review and revise the care plans, but maybe this one got missed. She was not sure why blood pressure medication was still care planned for Resident #2 when Resident #2 was no longer on blood pressure medication. She stated the care plans needed to have up to date and accurate information in them so as to provide staff with a resource on how to care for the residents. In an interview on 09/17/2025 at 10:44 AM, the DON stated the MDS coordinator was initially responsible for the clinical aspect portion of the care plans, but either herself or the ADON would be the one to look back and review the care plan was completed accurately. Then, the IDT reviewed and revised them quarterly and with changes in condition. The DON stated the clinical staff, to include herself, the ADON, and the MDS nurse, were ultimately responsible for reviewing and revising the clinical care plans. The DON also stated Resident #2's blood pressure medication should have been removed a long time ago, and she was not sure why it was never removed because Resident #2 had not been on blood pressure medication for a long time, and if the care plans were not updated with accurate or appropriate information, residents may not get the care they need. Record review of the facility's Comprehensive Care Plans policy, implemented 06/01/2025 and revised 06/02/2025, revealed 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 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive quarterly MDS assessment.