

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455608	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Hacienda Oaks at Beeville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's right to privacy for 1 (Resident #22) of 8 residents reviewed for privacy and dignity.</p> <p>The facility failed to ensure LVN-A provided privacy to Resident #22 while administering his medications in the middle of the dining room without permission.</p> <p>This failure could cause residents to feel uncomfortable, disrespected, and possibly a loss of dignity due to a lack of privacy.</p> <p>Findings included:</p> <p>Record review of Resident #22's face sheet dated 05/19/2025 revealed an [AGE] year-old male with an admission date of 08/06/2024. Pertinent diagnoses included Parkinsonism (a progressive neurological condition which affects movement and characterized by both motor and non-motor symptoms), Dysphagia (difficulty swallowing), Cognitive Communication Deficit (difficulties in communication which arise from impairment in cognitive processes such as attention, memory, perception, and executive function), Bipolar (mental health condition characterized by extreme mood swings which include emotional highs and lows) and Dementia (group of symptoms affecting memory, thinking, and social abilities).</p> <p>Record review of Resident #22's Quarterly MDS assessment 02/12/2025 revealed a BIMS score of 08, moderately impaired cognition.</p> <p>Record review of Resident #22's physician orders started 01/24/2025 revealed Depakote Sprinkles (Divalproex Sodium used to treat seizures, bipolar and migraines); Carbidopa - Levodopa (primarily used to manage the symptoms of Parkinson's Disease) started 08/06/2024; Tylenol Extra Strength started 11/14/2024.</p> <p>During an observation on 05/19/2025 at 8:00 AM revealed LVN-A crushed Resident #22's medication, mixed it with pudding, then walked from Hall A to the middle of the dining room and spoon fed Resident #22's medication to him in a dining room filled with other residents.</p> <p>(continued on next page)</p>

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN-A on 05/19/2025 at 8:15 AM, he stated he was nervous and could not remember if it was okay or not to give Resident #22's medication in the dining room. He stated he should have asked Resident #22 if he would like to have gone back to his room to take his medication or if he would like to have taken it in the dining room. LVN-A stated he could have caused Resident #22 to experience embarrassment or loss of dignity due to administering his medication in front of other residents without his permission.</p> <p>In an interview with LVN-C on 05/19/2025 at 9:22 AM she stated nurses sometimes got complacent to administering medication wherever the resident was during that given moment, but nurses should not be administering medications in public places such as hallways or dining rooms unless the residents gave permission to do so because it could cause the resident to become embarrassed.</p> <p>In an interview with the DON on 05/19/2025 at 5:27 PM she stated LVN-A should not have administered Resident #22's medication without asking for permission first. She stated this could have caused the resident to experience embarrassment, loss of dignity, or feel uncomfortable.</p> <p>Record review of in-service dated 05/19/2025 revealed staff were in-serviced when doing finger sticks, insulin, and any medication pass, residents must be taken to their room and provided privacy at all times.</p> <p>Record review of in-service dated 05/19/2025 revealed staff were in-serviced to never interrupt meal services to administer medications.</p> <p>Record review the facility's Medication Administration Policy (no implementation or revision date), revealed Policy Explanation and Compliance Guidelines: 7. Provide Privacy.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, transportation of linens designed, to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 linen carts and one (Resident #12) of 8 residents reviewed for infection control practices, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure LA D covered the linen cart on Hall A. 2. The facility failed to ensure LVN C washed/sanitized hands between glove changes while performing wound care on Resident #12. 3. The facility failed to ensure Resident #12's wound did not come in contact with a contaminated, soiled surface. <p>These failures could place residents that require wound care at risk for cross-contamination and infections.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 05/19/25 at 05:55 PM LA D was observed passing out clean laundry in Hall A with laundry cart uncovered. <p>In an interview on 05/19/25 05:57 PM, LA D stated when he walked into the facility with the laundry cart, the cart was covered but he uncovered it when he was passing out clothes to the residents. LA D was unaware the laundry cart was to be covered at all times.</p> <p>In an interview on 05/20/25 at 08:33 AM, the DON stated the laundry cart was supposed to be covered. The DON stated it must be covered to prevent cross contamination and other residents having access to the clothing. The DON stated she was going to start an in-service on infection control and laundry transportation services.</p> <p>In an interview on 05/20/25 at 09:26 AM, the Laundry Supervisor stated she was not aware the linen cart was supposed to be covered at all times while being transported. The Laundry Supervisor stated the linen cart was covered while transporting into the building then uncovered when clothes are being passed out. The Laundry Supervisor stated the linen cart should be covered at all times to prevent cross-contamination.</p> <ol style="list-style-type: none"> 2. Record review of Resident #12's face sheet dated 05/20/25 reflected a [AGE] year-old-female with an original admission date of 07/25/23. Diagnoses included pressure ulcer (open wound on the skin caused by long periods of constant pressure) of the sacral region (base of the spine supporting the pelvis), stage 4 (severe pressure ulcer that extends below the subcutaneous fat into deep tissue), severe chronic kidney disease, and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #12's physician orders dated 5/10/25 reflected:</p> <p>Wound care to stage 4 pressure ulcer at the sacrum 3 times a week and as needed until resolved. Cleanse/irrigate wound with normal saline and Vashe (wound cleanser). Pat dry with gauze. Apply collagen alginate (stimulates new tissue growth) to undermining (erosion that occurs beneath the edges of a wound, leading to a larger wound are with a smaller visible opening) and (cut to fit) Hydrofera blue (antibacterial wound dressing) to wound bed and cover with bordered dressing. Wound care every Tuesday, Thursday, and Saturday.</p> <p>During an observation of wound care 05/20/25 at 10:04 AM LVN C did not wash or sanitize hands after removing gloves and before placing new gloves on. The ADON and LVN C stopped wound care to get supplies, after providing wound care on Resident #12 and rolled Resident #12 on her back, leaving the wound uncovered on her visibly soiled brief. The ADON and LVN C redid Resident #12's wound care.</p> <p>In an interview on 05/20/25 at 11:17 AM LVN C stated she was nervous, and she should have washed or sanitized hands prior to placing new gloves on to prevent the spread of infection. LVN C stated Resident #12's wound should not have come in contact with her soiled brief. LVN C stated Resident #12's wound could get worse or become infected. LVN C stated the last infection control in-service was about a week ago but could not remember the date. LVN C stated her last hands-on skills check off was about a few weeks ago.</p> <p>In an interview on 05/20/25 11:18 AM, the ADON stated LVN C and all staff should wash or sanitize hands after removing gloves to prevent the spread of bacteria and infection. The ADON stated Resident #12's wound should have been covered and not have come in contact with her soiled brief due to contamination to wound and Resident #12's wound could get infected or become septic. The ADON stated a wound care specialist has come to the facility and provided hands on wound care training to nurses.</p> <p>In an interview on 05/20/25 11:32 AM, the DON stated LVN C should have washed or sanitized hands after removing gloves to prevent cross contamination. The DON stated Residents #12's wound should not have come in contact with her soiled brief because the wound could be introduced to bacteria and could get infected or septic. The DON stated she was going to conduct an in-service on infection control and wound care immediately.</p> <p>Record review of the facility's Infection Prevention and Control Program not dated reflected:</p> <p>Policy:</p> <p>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.</p> <p>12. Linens:</p> <p>a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection.</p> <p>d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's Hand Hygiene policy not dated reflected:</p> <p>Policy:</p> <p>All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.</p> <p>6. Additional considerations:</p> <p>a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>Record review of the facility's Wound Treatment Management not dated reflected:</p> <p>Policy:</p> <p>To promote wound healing of various wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>Based on observations, interview, and record reviews, the facility failed to provide the required 80 square feet per resident in 48 of 48 resident rooms (1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-27-28-29-30-31-33-34-35-36-37-38-39-41-42-43-44-45-46-48-49-50-51 and 52) in that:</p> <p>All 48 rooms did not account for 80 square feet per resident.</p> <p>This failure could restrict the amount of resident care equipment and resident ' s personal effects that could be accommodated in these resident rooms and limit the residents ' ability to move about the room.</p> <p>Findings were:</p> <p>Review of Health and Human Services Form 3740 Bed Classifications, dated 05/18/25, revealed 44 rooms with 2 beds, and 4 rooms (23, 24, 51, 52) with 3 beds.</p> <p>Beginning at 9:30 am on 05/18/25 during the facility ' s survey, this surveyor, using an agency laser measuring device, obtained measurements for all existing rooms. Rooms with 2 beds measured between 149 and 156.5 square feet. Rooms with 3 beds measured between 220.1 and 220.9 square feet. None of the rooms measured provided the required square feet per resident.</p> <p>On 05/18/25 at 10:50 am, the ADM provided a letter requesting a room size waiver for rooms 1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51 and 52. The ADM stated there had been no changes to the rooms.</p>		