

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/01/2026
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)		
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, interview and record review, the facility failed to develop a comprehensive care plan for each resident, consistent with the resident's rights, that includes measurable short-term and long-term objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #2 and Resident #41) of 8 residents reviewed for care plans. 1. The facility failed to ensure Resident #2's comprehensive care plan reflected the use of a soft touch call light. 2. The facility failed to ensure Resident #41's comprehensive care plan reflected what his PTSD triggers were. This failure could place residents at risk of not receiving individualized care and services to attain or maintain the residents' highest practicable physical, mental, and psychosocial wellbeing. 1. Record review of Resident #2's face sheet, dated 06/29/26, reflected an [AGE] year-old female, admitted on [DATE], diagnoses included: hemiplegia/hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting right dominant side, unspecified dementia (decline in cognitive function severe enough to interfere with daily life affecting memory loss, language, problem solving, and other cognitive abilities), peripheral vascular disease (narrowed arteries that reduce blood flow to the limbs), congestive heart failure (long-term condition that affects the heart's ability to pump blood), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), and anxiety disorder (uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #2's quarterly MDS assessment, dated 04/16/26, reflected a BIMS score of 15, which indicated intact cognition. The MDS reflected Resident #2 had impairment on both upper extremities and one lower extremity. Record review of Resident #2's care plan, dated 07/01/26, reflected [Resident #2] had impaired physical functioning related to hemiplegia/hemiparesis. Date initiated: 09/16/25. Interventions included: needs two staff for transfers, incontinent care, and repositioning. Resident #2's care plan did not reflect the soft touch call light. 2. Record review of Resident #41's admission record on 06/29/26 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included type 2 diabetes mellitus with hyperglycemia (chronic condition that happens when blood sugar levels are persistently high), hyperlipidemia (high cholesterol), essential (primary) hypertension (high blood pressure), alcoholic cirrhosis of liver (liver damage caused by drinking alcohol), vascular dementia, mild, with mood disturbance (problems with thought processes and memory caused by brain damage from impaired blood flow), non-compliance with medical treatment and regimen due to unspecified reason (when someone intentionally does not take their medication or follow their doctor's recommendations), and Post Traumatic Stress Disorder, unspecified (a psychiatric condition that occurs in people who have experienced or witnessed a traumatic event or series of traumatic events). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #41's quarterly MDS assessment dated [DATE] reflected a BIMS score of 7, which indicated moderate cognitive impairment. This MDS assessment also reflected an active diagnosis of PTSD. Record review of Resident #41's care plan dated 08/18/25 reflected the focus at risk for behaviors associated with PTSD initiated 04/22/26. The goal was Resident #41 would feel more peaceful and at ease with improved quality of life through the next review date, initiated on 04/22/26 with review date 08/17/26. The interventions were, create a calm and safe environment, reduce stimuli that may increase anxiety, encourage to express feelings and concerns, and identify specific triggers or situations that exacerbate anxiety, initiated on 04/22/26. Record review of Resident #41's psychosocial assessment dated [DATE] reflected in the social isolation section, question 8: Summary of sections above (assessment of mood, affect, and psychosocial well-being): Resident does not like to be bothered and does not like to talk about his past. He prefers to be left alone. Question 9 asked if the care plan was updated to reflect psychosocial well-being and mood components and was answered, yes. Record review of Resident #41's social service history and initial assessment dated [DATE] reflected Resident #41 was a truck driver and a veteran. The significant life experiences section reflected Resident #41 was married for many years, experienced a lot in life in the army as a truck driver. [FM] says he feels like [Resident #41] had a good life. Record review of Resident #41's trauma informed care assessment dated [DATE] reflected in section A-PTSD screen, the interviewer read the following statement to Resident #41, Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide, then asked if he had ever experienced this kind of event. Resident #41 answered, yes. Resident #41 denied he had nightmares about the event(s) or thought about the event(s) when he did not want to, tried hard not to think about the event(s) or went out of his way to avoid situations that reminded him of the event(s), had been constantly on guard, watchful, or easily startled, felt numb or detached from people, activities, or his surroundings, or felt guilty or unable to stop blaming himself or others for the event(s) or any problems the event(s) may have cause. In an interview on 07/01/26 at 10:00 am, Resident #41 asked what PTSD was then stated there was not anything anyone did that made him mad or anxious. In an interview on 07/01/26 at 11:30 am, the SSA stated on the trauma informed assessment on 05/11/26, Resident #41 answered yes he had been through something traumatic, but it did not bother him and he did not want to go into specifics. She stated as per nursing staff, Resident #41 had no symptoms, he was sleeping well and not requesting his melatonin, and he was not complaining of any issues. The SSA stated he never divulged if he had any triggers, but she felt trying to push him for information may trigger him because FM said Resident #41 liked to keep personal things private. She stated some of the interventions on Resident #41's care plan included create a calm and safe environment and encourage him to express triggers and concerns. The SSA stated she needed to update his care plan because asking him to express triggers and concerns could trigger him. She stated it was important to have updated care plans so facility staff continued to provide the best care for residents. She stated as things changed, they updated the care plan so staff were aware of the changes. She stated if something was not care planned appropriately or updated new staff or night staff who did not know the resident and what triggered them may unintentionally trigger the resident and cause a behavior that could have been avoided. The SSA stated the negative effect of triggering a behavior that could have been avoided could alter the resident's state of mind or feelings of depression and/or the resident could feel like they did something wrong when it was actually triggered by the facility. In an interview on 07/01/26 at 12:13 pm, the DON stated the way (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they knew what were triggers for residents with PTSD was through the resident assessment. The DON stated Resident #41 was uncooperative with the assessments and usually just answered no to all the questions or did not answer at all. She stated information about triggers were supposed to be on the care plan but his were not because he did not tell anyone what his triggers were. In an interview on 07/01/26 at 1:23 pm, RN A stated Resident #41 had divulged to her that he was involved in Vietnam and exposed to agent orange and that was why his fingers were discolored. RN A stated Resident #41 did not divulge any other information. She stated she was not aware of any triggers he had. RN A stated she had never seen him strike out at anyone and he was very quiet. She said she was not really familiar with the Resident #41's care plan and had never been informed of any triggers for him. She stated a negative effect of not knowing a resident's triggers for PTSD was there could be behavior issues with the resident. She said if something appeared to trigger a resident, she would just ensure the resident was calm and safe and would talk to him. In an interview on 07/01/26 at 2:05 pm, CNA B stated she was aware Resident #41 had PTSD. She stated he did get agitated at times. In regard to his triggers, she stated it just depended on his mood on any given day. CNA B stated one day something would get him upset and the next day the same thing would not upset him. She stated when she talked to Resident #41 and he did not answer her, she would just leave him alone and return later. She stated as far as she knew she had not figured out his triggers and he had not divulged any. CNA B stated no one had informed her he had any triggers. CNA B stated a negative effect of not care planning or informing staff of triggers for a resident could cause the resident to lash out at staff and place them in a predicament and for the resident it could bring him down or make him not motivated or not his normal self. In an interview on 07/01/26 at 2:15 pm, CNA C stated she had heard that Resident #41 had PTSD, but she had never seen or heard that he had shown any signs or symptoms. She stated no one had told her he had triggers and it was not in his care plan. CNA C stated she had never seen him have any issues while working down his hall. She stated a negative effect of not care planning or informing staff of triggers a resident may have could cause the resident to get angry or mad and take it out on staff or it could even cause him to have a fall. In an interview and observation, on 07/01/26 at 2:25 pm, Resident #2 stated she was fine. Resident #2 was asked basic questions but she did not respond. Resident #2 was observed with no visible injury. Resident #2 had a soft touch call light within reach. In an interview, on 07/01/26 at 2:50 pm, the ADON stated Resident #2 had a soft touch call light but she was not sure since when. The ADON stated she did not know how much Resident #2 used the call light because she did not move around much but the staff checked on her frequently. The ADON stated the MDS Nurse developed and updated the care plans. In an interview, on 07/01/26 at 3:00 pm, the MDS Nurse stated she developed and updated care plans but it was also a team effort. The MDS Nurse stated Resident #2 had a soft touch call light and that should have been added to her care plan as an intervention. The MDS Nurse stated there was no negative outcome for Resident #2 as staff checked on her frequently. The MDS Nurse stated it was important for the care plan to be developed with accurate information to ensure all staff were aware of how to care for the resident. In an interview on 07/01/26 at 3:11 pm, the MDS nurse stated until today (07/01/26) there were no triggers listed anywhere in Resident #41's chart. She stated she checked his trauma assessments, previous social services notes, progress notes, previous MDS assessments, and other assessments and was not able to find any triggers noted. The MDS nurse stated as of today, his triggers were documented as, asking too many questions aggravated him which was documented by the SSA. She stated care plan updates were a team effort upon new information being known. She stated she also updated care plans when she did her MDS assessments. The MDS nurse stated it was important to update care plans so everyone was aware of the resident's wishes and how to take care of them. She (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if care plans were not updated, the staff would not be aware of the resident's preferences. The MDS nurse stated she had monthly MDS calls with their corporate MDS personnel. She stated she completed the MDS assessments and the regional RN looked over and signed them. The MDS stated Resident #41 had not had any negative outcomes from his triggers not being care planned. In an interview, on 06/27/26 at 3:30 pm, the DON stated care plans were developed and updated by the team, including the MDS Nurse, the ADON, herself. The DON stated Resident #2 had a soft touch call light which should have been included in her care plan. The DON stated there was no negative outcome or risk of injury for Resident #2 as staff checked on her frequently and Resident #2 was vocal to make her needs known. The DON stated it was important for the care plan to be accurate to ensure everyone was aware of the resident's needs and how to care for her. Record review of the facility's Comprehensive Care Plans policy, dated 06/01/25 and revised 06/02/25, reflected in part: Policy: 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. Definitions: Person-centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. Professional standards of quality" means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. "Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma-informed care as indicated. 3. The comprehensive care plan will describe, at a minimum, the following: g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific.: interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 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 and 52) in that: The facility failed to provide the required 80 square feet per resident for all 48 rooms. 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. The findings included: Record review of Health and Human Services Form 3740 Bed Classifications, dated 06/29/26, revealed 44 rooms with 2 beds, and 4 rooms (23, 24, 51, 52) with 3 beds. During an investigation beginning at 11:30 am on 06/29/26 during the facility's survey, an agency laser measuring device was used to obtain measurements for all existing rooms. Rooms with 2 beds measured between 151 and 160 square feet. Rooms with 3 beds measured between 219 and 234 square feet. None of the rooms measured provided the required square feet per resident. During interview and record review on 06/29/26 at 3:00 pm, 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- and 52. The ADM stated there had been no changes to the rooms.		