

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Oak Village Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 204 Oak Drive S Lake Jackson, TX 77566	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents receive proper treatment and assistive devices to maintain vision abilities for 1 (Resident # 1) of 4 residents reviewed for quality of care. The facility failed to provide necessary arrangements to repair broken eyeglasses for Resident # 1. This failure could lead to injury and/or decreased quality of life. Findings included: Record review of Resident # 1's face sheet dated, 6/9/2026 revealed a [AGE] year old male, admitted to the facility on [DATE]. Relevant diagnosis included Parkinson's Disease without Dyskinesia, without mention of fluctuations (a stage of the condition where the patient has smooth, relatively stable symptom control) and Dementia with other behavioral disturbance (agitation, aggression, anxiety, depression, delusions, wandering, and sundowning). Record review of Resident # 1's MDS assessment submitted on 3/19/2026, reflected BIMS score of 14, indicating cognitively intact. Resident # 1 was assessed as having vision impairment and the resident required corrective lenses. Record review of Resident # 1's Care Plan Report, revised on 5/7/2026, revealed Resident # 1 had impaired visual function. Interventions were to ensure appropriate visual aids (glasses) were available to support Resident # 1's participation in activities; monitor/document/report to MD the following signs and symptoms of acute eye problems: change in ability to perform ADL's, decline in mobility. In an interview on 6/10/2026 at 10:00 am Family Member # 1 stated that Resident # 1's glasses had been broken for months. She stated that she reported the concern to the Administrator two or three months ago. She stated that the Administrator told her that the Ophthalmologist was coming to the facility on July 2, 2026. She stated that it was unacceptable as Resident # 1's glasses were taped and broken. Family Member # 1 stated that the facility should be held accountable as Resident # 1's needs were not met. She stated that Resident #1 was vision impaired and needed to wear eyeglasses. She stated that Resident #1's eyeglasses were broken he cannot wear the glasses, therefore, this had an effect on his vision as he cannot see. She stated that staff offered to pay for glasses for Resident # 1. She stated that she felt it was the facility's responsibility to replace or repair Resident # 1's glasses. She stated that she was told that Resident # 1's eyeglasses could be sent out for repair, but it would take a while before they would be returned to the facility. Record review of the facility's concern and grievance report, dated 6/5/2026, revealed in part [Family Member # 1] came into the DON's office stating [Resident # 1's] glasses were broken. [Family Member #1] asked when [Resident # 1's] next optometry visit. The final was resolution was Resident # 1 had a scheduled Optometry visit on July 2, 2026. In an interview with Social Worker A on 6/10/2026 at 11:10 am, she stated that she was aware that Resident # 1's eyeglasses were broken. She stated that it was brought to her attention this month. She stated that Resident # 1 was scheduled to see the Ophthalmologist on July 2, 2026. She stated that Resident #1's eyeglasses were not sent out for repair as it would be a while before the eyeglasses would be fixed and returned. In an interview with RN A on 6/10/2026 at 11:38 am, he stated that he was aware that Resident # 1's eyeglasses were broken. He stated that he did not know how Resident # 1's eyeglasses were broken. He stated that he fixed Resident #1's eyeglasses by taping them. He stated that he did not inform anyone that Resident # 1's eyeglasses needed to be repaired or replaced. During an observation and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676307
		If continuation sheet Page 1 of 6

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 6/10/2026 at 1:35 pm with Resident #1's consent revealed Resident # ?1 glasses were observed on the top of the dresser across from his bed and they were taped with white colored tape where the lens met the hinges on the right side and bilaterally (two sides) covered in tape at the temple tip. The eyeglasses appeared crooked. Resident # 1 stated the the eyeglasses were broken a months ago when he fell out of the wheelchair in the hallway and landed on his face. In an interview with Family Member #2 on 6/10/2026 at 4:40 pm she stated that Resident #1's eyeglasses had been broken for about 3 months. She stated that she did not know how Resident # 1's eyeglasses were broken. She stated that staff taped the glasses up. She stated that Resident # 1 did not wear his eyeglasses due to the eyeglasses being broken. She stated the eyeglasses were normally on the counter. Record review of the facility's resident rights policy dated February 2021, revealed the following in part: 1. Federal and stated laws guarantee certain basic right of this facility. These rights include the resident's right to: a) a dignified existence.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 out of 1 residents (Resident #1) reviewed for adequate supervision, accidents, and hazards. CNA A and CNA B failed to provide adequate supervision to Resident #1 during a Hoyer lift transfer and Resident #1 sustained a skin tear to his right shin. This failure could place residents at risk for injury and harm. Findings included: Record review of Resident #1's admission Record revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses, Parkinson's (a progressive neurological disorder that primarily affects movement), dementia (a decline in mental abilities, like memory, reasoning, and communication that is severe enough to interfere with daily life), dysphagia (difficulty or discomfort in swallowing food, liquids or even saliva), neoplasm of prostate (any abnormal growth or tumor in the prostate gland), and chronic pain syndrome (a condition where persistent pain lasts beyond the standard healing time [typically 3-6 months] and is accompanied by emotional and behavioral symptoms such as depression, anxiety and severe disruptions to daily life). Record review of Resident #1's Quarterly MDS (Minimum Data Set) dated 03/19/2026 revealed he had a BIMS score of 14 out of 15 indicating his cognition was intact. Section GG regarding Resident #1's Activities of Daily Living assistance revealed he was dependent on at least 2 staff members for transfers. During an observation and interview with Resident #1 on 06/10/2026 at 1:35 PM of incontinent and wound care. Observation of his right shoulder abscess, wound care was performed by the Wound Care Nurse and assisted by CNA A, without concerns. Observed incontinent care performed by CNA A and assisted by the Wound Care Nurse with no concerns. When staff rolled Resident #1 back onto his back, observed 3 regular sized tan band-aids across his right shin. The Wound Care Nurse said she did not know what the 3 band-aids were for because no one told her there was any wound or injury. CNA A then said she knew about the band-aids on Resident #1's right shin because she accidentally bumped his leg on Sunday , 06/07/2026 during an electric Hoyer lift transfer with CNA C. CNA A said they were transferring Resident #1 from his bedside reclining chair, back into his bed and during the transfer she thought she heard a bump or noise, but Resident #1 never complained or made a sound. CNA A said that once she and CNA C got Resident #1 back in bed, they noticed his right shin bleeding and a skin tear. CNA A said they told LVN A immediately. The Wound Care Nurse removed the 3 band-aids to expose a linear vertical skin tear approximately 4 cm in length. There was no active bleeding. Interview with LVN A on 06/10/2026 at 1:47 PM, LVN A said CNA A and CNA B did tell him about Resident #1's skin tear on Sunday 06/07/2026 and he did not complete an SBAR or incident report and he did not tell the DON or Wound Care Nurse. LVN A said he was supposed to complete an SBAR and Incident Report in Resident #1's EMR. LVN A said he must have gotten busy and forgot to complete documentation and report the incident. LVN A said they did call the MD on call for Resident #1 after assessing the injury and he did put a treatment in place but did not document an order for treatment. LVN A said it was his failure to report as trained and complete documentation per facility policy and procedure and repeated that he must have gotten busy after that and forgotten to do it. Interview with the DON on 2:20pm , the DON said no one told her about Resident #1's skin tear and it would be considered risk management and an SBAR change in condition and incident and accident report as well as a progress note should have been documented by LVN A. The DON said all staff had been trained on how and when to complete incident and accident reports, SBAR's and progress notes. The DON said she went to assess Resident #1, and the skin tear had a treatment in place and the MD and RP had been notified. The DON said an incident and accident report would be completed and the Administrator would also be (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified. Interview with CNA C on 06/10/2026 at 2:23pm who said she and CNA A were transferring Resident #1 using the electric Hoyer lift on Sunday, 06/07/2026 and were transferring Resident #1 from his bedside reclining chair, back into his bed. CNA C said once she and CNA A got Resident #1 back in bed, they noticed his right shin bleeding and a skin tear. CNA C said they told LVN A, who was the charge nurse for Resident #1 on 06/07/2026, immediately. Record review of Resident #1's EMR for assessments on 06/10/2026 at 3:22pm revealed no incident or accident report. Record review of Resident #1's nursing progress notes from 06/07/2026 through 06/10/2026 revealed staff documented by exception, and Resident #1 had no progress notes on 06/07/2026 and no progress notes regarding a Hoyer lift incident/accident. There were no nursing progress notes regarding skin tears. Record review of facility's incident and accident log with a date range of 12/01/2025 through 06/09/2026 revealed no skin tear for Resident #1. Record review of facility's Hoyer -Total Mechanical Lift in-service competency acknowledgement dated 04/03/2026 revealed CNAs A and B received training for the use of a two-person electric and manual Hoyer lift. Continued record review revealed LVN A completed their training on 04/02/2026. Record review of facility policy and procedure dated 2001 and titled, Accidents and Incidents-Investigating and Reporting revealed in part: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation 1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place. b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.). c. The circumstances surrounding the accident or incident. d. Where the accident or incident took place. e. The name(s) of witnesses and their accounts of the accident or incident. f. The injured person's account of the accident or incident. g. The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions. h. The date/time the injured person's family was notified and by whom. i. The condition of the injured person, including his/her vital signs. j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.). k. Any corrective action taken. l. Follow-up information. m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report. 3. This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device. 5. The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. 6. The director of nursing services shall ensure that the administrator receives a copy of the Report of Incident/Accident form for each occurrence. 7. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents requiring Hoyer lift transfers on 2ut of 2 hallways, reviewed or environment. The facility failed to remove a broken electric Hoyer lift (a mechanical assistive device that uses a sling and sturdy frame to safely transfer immobile residents to and from bed) from continued use rotation on facility residents requiring Hoyer lift transfers. The facility failed to repair a broken electric Hoyer lift that was used for Sunset and Rodeo facility hallways. These failures could place residents at risk of injury, unsafe transfers, and environment. During an observation and interview on 6/10/26 at 3:02 P.M., in the common area of the Sunset hallway, of 1 of 2 electric Hoyer lifts, with CNA A revealed the aide identified the lift as one of the Hoyer lifts she used to transfer facility residents. The Hoyer lift's rectangular control box located near the base of the lift was beige in color and separated in the middle exposing jagged inner plastic edges. CNA A said there were 2 electric Hoyer lifts, but she was pretty sure she had used the broken Hoyer lift that day because there was one on each hall and they used them interchangeably depending on which lift was free for use at the time it was needed. CNA A said no residents were injured during her transfers when she used the lift. CNA A said staff was not sure to whom they should have reported the issue to but said she could have told the Maintenance Director or written it in the maintenance repair log, located at the nursing station. During an observation and interview with Corporate and DON on 6/10/26 at 3:08 P.M., The DON and Corporate both said none of the staff had notified them that the electric Hoyer lift needed to be repaired, and they both said it needed to be fixed so it would not cause any injury to a resident. Corporate removed the electric Hoyer lift from the common area and put it into the Administrator's office. She said that was to prevent staff from continuing to use the device until it was fixed so no resident could be injured. Corporate said she was notifying the facility Maintenance Director and the company that serviced the Hoyer lift. In an interview with the DON on 6/10/26 at 3:10 P.M., she said the staff were trained to report broken or malfunctioning equipment to administrative management and write repair issues in the maintenance repair logs as there was a log located at each of the two facility nursing stations. The DON said she did not know why staff had not done so and did not know why staff had not notified her. The DON said a resident could be injured by the open jagged edges of the box and could not understand why staff continued to use the device in that condition because there was a manual Hoyer lift and one other electric Hoyer lift on the other unit. During an observation and interview on 6/10/26 at 3:12 P.M., in the Administrator's office with CNA B revealed the aide said staff used the electric Hoyer lift. CNA B said that particular electric Hoyer lift had been broken for a while but could not say exactly how long. CNA B said the electric Hoyer lift not only had the cracked and open beige box at the bottom, near the base of the Hoyer lift, but the emergency mechanical lowering descent mechanism was also broken. CNA B demonstrated that the red collar freely slid up and down the column, instead of being engaged to lower the boom (the part that supports the weight of the resident) at a safe controlled rate when the battery was not in use. CNA B said staff had not specifically told anyone in management about it because staff thought everyone already knew it was broken. CNA B said staff probably should have reported the issues with the lift to management and written it in the maintenance repair log at the nurses' station, because that was what they had been trained to do. During a follow up observation and interview on 6/10/26 at 3:18 P.M., with Corporate in the Administrator's office, of the electric Hoyer lift, revealed she said no staff reported to the Administrator or DON that the lift was broken and that the emergency mechanical lowering descent mechanism was also broken. Corporate said the Maintenance Director had been notified and the facility had already ordered a rental electric Hoyer lift and said she would provide the invoice for the rental and the service repair request the facility had submitted. Corporate said if the emergency mechanical lowering descent mechanism was broken, a resident could get (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stuck in the air if the battery/electrical went out and there would be no way to lower the resident to safety. Corporate said the broken and malfunctioning parts on the electric Hoyer lift should have been reported and they were working on getting it fixed ASAP. Corporate said they removed the device from rotation and employee access, so it would not continue to be used while in disrepair and so no residents could be injured by it. Observation on 6/10/26 at 3:23 P.M., of a second electric Hoyer lift in room [ROOM NUMBER] revealed it was in good working condition. During an interview with the facility Maintenance Director on 6/10/26 at 3:48 P.M., he said no one notified him about the broken electric Hoyer lift and he was only notified today, by Corporate, the DON and Administrator. The Maintenance Director said the staff should have notified him of the broken electric Hoyer lift using the maintenance logs because there was one located on each of the two facility nursing stations. The Maintenance Director said the electric Hoyer lift needed to be fixed so it would work properly and if the emergency mechanical lowering descent mechanism was broken, a resident could get stuck in the air if the battery/electrical went out and there would be no way to lower the resident to safety. He said the jagged edges of the box at the bottom could cut a resident. The Maintenance Director said the device should be fixed and staff should have reported the issue. Record review of the facility maintenance logs from each nursing station for July 2025 through June 2026 revealed no entries for repairs to an electric Hoyer lift. Record review of a handwritten list of residents who required Hoyer lift transfers revealed a total of 18 residents. Record review of the facility's policy titled Lifting Machine, Using a Mechanical, dated Revised July 2017, revealed in part: 6. Test the lift control. Ensure the emergency release feature works. 8. Make sure that all necessary equipment (slings, hooks, chains, straps and supports) is on hand and in good condition.		