

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Beaumont Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 795 Lindbergh Dr Beaumont, TX 77707	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664</p> <p>Based on interviews and record reviews, the facility failed to ensure the right to formulate an advance directive was provided for 1 of 4 residents reviewed for resident rights. (Resident #5)</p> <p>The facility did not have a valid Out of Hospital-Do Not Resuscitate (OOH-DNR) for Resident #5.</p> <p>This failure could place residents at risk of lifesaving procedures being performed against their wishes resulting in bruising, broken ribs, and possibly being brought back to life in an unaware and unresponsive state.</p> <p>Findings included:</p> <p>Record review of physician orders for [DATE] indicated Resident #5 was an [AGE] year-old female readmitted on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), hypertension (condition in which the force of the blood against the artery walls is too high), and abdominal aortic aneurysm (enlargement of the main blood vessel that delivers blood to the body, at the level of the abdomen). She had an order dated [DATE] for DNR.</p> <p>Record review of the current MDS assessment dated [DATE] indicated Resident #5 was alert to person, place, and time with a BIMS of 11 indicating she had moderately impaired cognition.</p> <p>Record review of the EMR on [DATE] at 09:33 a.m. indicated Resident #5 had a scanned OOH-DNR dated [DATE] with no printed name of physician and no license number of physician.</p> <p>During an observation and interview on [DATE] at 11:05 a.m., Resident #5 was up in her recliner in her room. She said she did not want CPR done.</p> <p>During an interview on [DATE] at 02:00 p.m., the DON said she had just started at the facility yesterday, but she knew DNRs should be completed or they can be deemed as invalid. She said missing physician information would make a DNR invalid. She said they would start CPR and possibly bring the person back to life while possibly breaking rib bones.</p> <p>During an interview on [DATE] at 03:07 p.m., the former DON/Corporate Nurse said the SW usually did the DNRs.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 03:23 p.m., the SW said DNRs without complete information would be invalid. She said Resident #5's DNR would be invalid due to not having the physician information completed.</p> <p>Record review of a Do Not Resuscitate Order policy revised [DATE] indicated Policy Interpretation and Implementation: 2. A Do Not Resuscitate (DNR) order form must be completed and signed by the Attending Physician and resident .</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 1 resident (Resident #42) reviewed for enteral feeding.</p> <p>LVN A failed to verify placement of Resident #42's G-tube by checking for residual (fluid and contents that remain in the stomach) before enteral administration of water and medications.</p> <p>This failure could place residents receiving enteral nutrition and medications at increased risk of not receiving proper nutrition, infection, and aspiration.</p> <p>Findings include:</p> <p>Record review of Resident #42's physician orders dated April 2024 indicated she was [AGE] years old and admitted to the facility 11/27/23. Her diagnosis included dysphagia (difficulty or discomfort swallowing) and aphasia (affects the ability to communicate). Orders indicated she was NPO (nothing by mouth) and was to receive all feedings and medications via G-tube (a tube inserted through the stomach that brings nutrition directly to the stomach).</p> <p>Record review of a care plan last revised 12/08/23 indicated Resident #42 had a feeding tube related to dysphagia, history of aspiration (breathing in a foreign object such as food), and swallowing problem. Interventions included to verify tube placement prior to use.</p> <p>Record review of the most recent quarterly MDS dated [DATE] indicated Resident #42 had severely impaired cognition, was dependent for all ADLs, and received her nutrition and hydration via G-tube.</p> <p>During an observation during medication administration on 04/02/24 at 9:18 a.m., LVN A checked placement of Resident #42's G-tube by inserting 10ml of air into the tube and listening at the abdomen for the swish of air. She then administered water flushes and medications through the G-tube.</p> <p>During an interview on 04/02/24 at 9:28 a.m., LVN A said she normally checked placement of a G-tube by auscultation (listening for a swish of air inserted into the abdomen with a stethoscope) and checking for residual in the stomach. She said she forgot to check for residual today. She said possible negative outcome of not performing a residual check for placement of the G-tube could be administering medications to a stomach that was too full. She said she had received training on G-tubes at nursing school and during orientation at the facility.</p> <p>During an interview on 04/03/24 at 10:15 a.m., the DON said she was not aware of the recommendation in the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities that auscultation was no longer recommended for checking placement of a feeding tube. She said the facility policy indicated placement could be checked by auscultation or aspiration of residual. She said possible negative outcome of not checking placement of a G-tube by residual check could be administration of medications and/or feeding outside of the stomach.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/03/24 at 10:20 a.m., the Corporate Nurse said that the corporation was in process of reviewing and updating facility/corporate policies and she would bring the Confirming Placement of Feeding Tube policy to the attention of those updating policies. She said she was the former DON at the facility and all LVNs had received training on G-tubes and other skills during orientation to the facility. The training was given by staff LVNs, the ADON, and the DON.</p> <p>Record review of the facility policy titled Confirming Placement of Feeding Tubes revised March 2015 indicated .Observe for placement by: a. verify placement by auscultating stomach or b. verify placement by residual: little to no residual may suggest that the tube has migrated from the stomach to the esophagus.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 3 of 7 residents (Residents #9, #47, and #104) reviewed for unnecessary medications.</p> <p>The facility did not have appropriate indications for medications based on Resident #9's, #47's, and #104's diagnoses.</p> <p>This failure could place residents at risk of complications related to receiving unnecessary medications.</p> <p>Findings included:</p> <p>1. Record review of the physician orders dated April 2024 for Resident #9 indicated she was a [AGE] year-old female readmitted on [DATE] with diagnoses including type 2 diabetes and morbid (severe) obesity due to excess calories. The orders indicated the resident had an order dated 08/16/23 indicated she was to receive Ozempic subcutaneous solution (used to treat weight loss) every Friday related to type 2 diabetes mellitus.</p> <p>Record review of a Nurse Note dated 03/22/24 indicated Resident #9 was trying to lose weight and was taking Ozempic to help with weight loss.</p> <p>During an observation and interview on 04/01/24 at 09:36 a.m. Resident #9 was a very large built person in a bariatric bed. She said she had started taking Ozempic for weight loss and was hoping it would help some because she wanted to lose weight.</p> <p>During an interview on 04/02/24 at 02:00 p.m. the DON said medications should have a diagnosis for the medication. She said the indications for Resident #9 were symptoms and drug classifications, not diagnoses.</p> <p>During an interview on 04/02/24 at 03:08 p.m. the former DON/Corporate Nurse said medications should have appropriate diagnoses for their medication indication. She said Resident #9 was taking the Ozempic for weight loss and not for her diabetes.</p> <p>2. Record review of the physician orders dated April 2024 for Resident #47 indicated she was a [AGE] year-old female admitted on [DATE] with diagnoses included senile degeneration of the brain and dementia. The orders indicated the resident had an order dated 03/22/24 for valproic acid (anticonvulsant) for dementia.</p> <p>During an interview on 04/02/24 at 02:00 p.m. the DON said dementia was not an appropriate indication Resident #47's medications.</p> <p>3. Record review of the physician orders dated April 2024 for Resident #104 indicated she was an [AGE] year-old female admitted on [DATE] with diagnoses including paroxysmal atrial fibrillation (a type of irregular heartbeat) and restless leg syndrome. The orders indicated the resident had:</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>* an order dated for Eliquis (blood thinner) for blood thinner;</p> <p>* an order dated for pramipexole dihydrochloride (used to treat restless leg syndrome) for antiparkinson's.</p> <p>During an interview on 04/02/24 at 09:20 a.m. Resident #104 said she did not have Parkinson's, but she took medication for her restless legs.</p> <p>During an interview on 04/02/24 at 02:00 p.m. the DON said medications should have an appropriate diagnosis for their use.</p> <p>During an interview on 04/02/24 at 03:08 p.m. the former DON/Corporate Nurse said medications should have appropriate diagnoses for their indication.</p> <p>Surveyor requested a medication policy related to medications and diagnoses on 04/03/24 from the DON and no policy was provided.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664</p> <p>Based on interview and record review, the facility failed to ensure residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 3 residents reviewed for unnecessary psychotropic drugs. (Resident #47)</p> <p>The facility failed to ensure Resident #47 had an appropriate diagnosis or adequate indication for the use of Trazadone (an antidepressant used to treat depression) and Zoloft (an antidepressant used to treat depression).</p> <p>This failure could place residents at risk for receiving unnecessary medication, having unnecessary medication side effects, and a decreased quality of life.</p> <p>Findings included:</p> <p>Record review of the physician orders dated April 2024 for Resident #47 indicated she was an [AGE] year-old female admitted on [DATE] with diagnoses included senile degeneration of the brain (mental deterioration associated with aging) and dementia (loss of cognitive functioning). The orders indicated she had the following medications:</p> <ul style="list-style-type: none"> * an order dated 02/23/24 for Trazadone (antidepressant) for dementia; and * an order dated 02/23/24 for Zoloft (antidepressant) for dementia. <p>During an interview on 04/02/24 at 02:00 p.m. the DON said dementia was not an appropriate indication Resident #47's medications.</p> <p>Surveyor requested a medication policy related to medications and diagnoses on 04/03/24 from the DON and no policy was provided.</p>