STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455561	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Health Care Center	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)
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** 22183 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for residents that included their specific needs as identified in each resident's comprehensive assessment for 2 of 10 residents (Residents #12 and #22) reviewed for person-centered care plans. Residents #12 and #22 did not have care plans developed for oxygen therapy. This failure could place residents at risk of not receiving proper care or inadequate oxygen support which could result in diminished physical, mental and psychosocial well-being. The findings included: 1. Record review of the face sheet dated 05/14/25 indicated Resident #12 was admitted on [DATE] and was [AGE] years old. Her diagnoses included acute respiratory distress, chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #12 MDS had active diagnosis of debility, cardiorespiratory conditions, acute respiratory distress, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, shortness of breath with exertion and received oxygen therapy continuous. Record review of the undated care plan on 05/14/25 indicated Resident #12 did not have a care plan related to her receiving oxygen therapy. Record review of the physician's orders for Resident #12 dated 05/12/25 indicated no order for oxygen administration. Record review of the nursing progress notes dated 05/08/25 indicated Resident #12 Resident returned to facility via wheelchair accompanied by 1 personnel from hospital . Dx: chronic pain BLE. Current vitals: BP 122/64, HR 72, RR 21, SP02 98% 2L[PM](of Oxygen) and Temp 98.8 . During an observation on 05/12/25 at 09:35 a.m., Resident #12's concentrator setting indicated infusing at the rate of 3 LPM per concentrator and she was asleep in her bed with the oxygen nasal cannula on. (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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(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	During an observation on 05/12/25 at 2:07 p.m., Resident #12's concentrator setting indicated infusing at the rate of 3 LPM per concentrator and she was sitting up in her wheelchair. Resident #12 said she was on oxygen for shortness of breath and that it helped her breath better. During an observation and interview on 05/12/25 at 2:30 p.m., LVN A verified Resident #12's concentrator was set on 3 LPM. LVN A said Resident #12 did not have an order for administration of oxygen. LVN A said Resident #12 used oxygen for shortness of breath. 2. Record review of the face sheet dated 05/14/25 indicated Resident #22 was admitted on [DATE] and was [AGE] years old. His diagnoses included essential hypertension, acute cough and chronic obstructive pulmonary disease. Record review of the annual MDS assessment dated [DATE] indicated Resident #22 MDS had active diagnosis of medically complex conditions, hypertension, chronic obstructive pulmonary disease. Record review of the undated care plan on 05/14/25 indicated Resident #22 did not have a care plan related to him receiving oxygen therapy. Record review of Resident #22's physician's orders dated 05/12/25 indicated no order for oxygen administration. Record review of Resident #22's nursing progress notes dated 04/25/25 indicated .cough; O2 sat: 87% on room air. Resident placed on 3 L[PM] NC, O2 improved to 93%. During an observation on 05/12/25 at 2:17 p.m., Resident #22's concentrator setting indicated infusion at the rate of 2 LPM per concentrator and he was lying in bed watching TV. Resident #22 said he was on oxygen most of the time for shortness of breath. During an observation and interview on 05/12/25 2:35 p.m., LVN A verified Resident #22's concentrator was set to 2 LPM. LVN A said Resident #22 did not have an order for administration of oxygen. LVN A said Resident #22 used oxygen for shortness of breath. During an observation and interview on 05/14/25 3:35 p.m., the DON verified Resident #12's concentrator was set on 3 LPM and Resident #22's concentrator was set on 2 LPM. The DON said oxygen therapy should have been included on Residents #12 and #22's care plans. After the DON reviewed Resident #12 and 22's care plans, she agreed there were missing care plans specific to the resident current needs of oxygen and did not know why or how it was missed. The DON said no one person was responsible for completing care plans and that it was the responsibility of all administrative nurses of the interdisciplinary team. The DON said she expected the team to complete care plans and to make sure they reflected the current care needs of the resident. Record review of facility undated policy titled Comprehensive Care Plan read in part . be developed for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs and ALL services that are been identified in the resident's comprehensive assessment . 3. The comprehensive care plan will describe, at minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . 4. The comprehensive care plan will be prepared by an interdisciplinary team .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22183 Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 4 of 8 residents (Residents # 12, # 22, #210 and #259) reviewed for respiratory therapy. The facility failed to ensure Residents #12 and #22 had a physician order for oxygen and was care planned. The facility failed to ensure Resident #210 was set on 3 LPM per oxygen concentrator (machine that takes air from your surroundings and extracts oxygen and filters it into purified oxygen to breathe). The facility failed to keep the oxygen concentrator filter clean for Resident #259. These failures could place residents at risk of receiving incorrect or inadequate oxygen support which could result in a decline in health. Findings include: 1. Record review of the face sheet dated 05/14/25 indicated Resident #12 was admitted on [DATE] and was [AGE] years old. Her diagnoses included acute respiratory distress, chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #12 MDS had active diagnosis of debility, cardiorespiratory conditions, acute respiratory distress, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, shortness of breath with exertion and received oxygen therapy continuous. Record review of the undated care plan on 05/14/25 indicated Resident #12 did not have a care plan related to her receiving oxygen therapy. Record review of Resident #12's physician's orders dated 05/12/25 indicated no order for oxygen administration. Record review of the nursing progress notes dated 05/08/25 indicated Resident #12 Resident returned to facility via wheelchair accompanied by 1 personnel from hospital . Dx: chronic pain BLE. Current vitals: BP 122/64, HR 72, RR 21, SP02 98% 2 L[PM] (of Oxygen) and Temp 98.8 . During an observation on 05/12/25 at 09:35 a.m., Resident #12's concentrator setting indicated infusing at the rate of 3 LPM per concentrator and she was asleep in her bed with the oxygen nasal cannula on. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 05/12/25 at 2:07 p.m., Resident #12's concentrator setting indicated infusing at the rate of 3 LPM per concentrator and she was sitting up in her wheelchair. Resident #12 said she was on oxygen for shortness of breath and that it helps her breath better. During an observation and interview on 05/12/25 2:30 p.m., LVN A nurse assigned to resident verified the concentrator was set on 3 LPM. LVN A said Resident #12 did not have an order for administration of oxygen. LVN A said Resident #12 used oxygen for shortness of breath and she would get an order for the oxygen. During an observation and interview on 05/13/25 at 09:00 a.m., Resident #12's said she had just finished her breakfast and her breathing was ok. Resident #12's concentrator setting indicated infusion at the rate of 3LPM and she was sitting up in her wheelchair. During an observation and interview on 05/14/25 at 09:10 a.m., Resident #12 was sitting up in her wheelchair doing a word search puzzle and said she had no breathing problems at this time. Resident #12's concentrator setting indicated infusion at the rate of 3 LPM. 2. Record review of the face sheet dated 05/14/25 indicated Resident #22 was admitted on [DATE] and was [AGE] years old. His diagnoses included essential hypertension, acute cough and chronic obstructive pulmonary disease. Record review of the annual MDS assessment dated [DATE] indicated Resident #22 MDS had active diagnosis of medically complex conditions, hypertension, chronic obstructive pulmonary disease. Record review of the undated care plan on 05/14/25 indicated Resident #22 did not have a care plan related to him receiving oxygen therapy. Record review of Resident #22's physician's orders dated 05/12/25 indicated no order for Oxygen administration. Record review of Resident #22's nursing progress notes dated 04/25/25 indicated .cough; O2 sat: 87% on room air. Resident placed on 3L NC, O2 improved to 93%. During an observation on 05/12/25 at 09:27 a.m., Resident #22's concentrator setting indicated infusion at the rate of 2LPM per concentrator and he was asleep in his bed with the oxygen nasal cannula on. During an observation and interview on 05/12/25 at 2:17 p.m., Resident #22's concentrator setting indicated infusion at the rate of 2LPM per concentrator and he was lying in bed watching TV. Resident #22 said he was on Oxygen most of the time for shortness of breath. During an observation and interview on 05/12/25 at 2:35 p.m., LVN A verified Resident #22's concentrator was set on 2 LPM. LVN A said Resident #22 did not have an order for administration of oxygen. LVN A said Resident #22 used oxygen for shortness of breath and she would get an order for the oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 05/13/25 at 08:45 a.m., Resident #22's said he had just finished his breakfast and his breathing was good. Resident #22's concentrator setting indicated infusion at the rate of 2 LPM. During an observation and interview on 05/14/25 at 09:00 a.m., Resident #22 was lying in bed and said he was ok and breathing fine at this time. Resident #22's concentrator setting indicated infusion at the rate of 2 LPM. During an interview on 05/14/25 2:35 p.m., LVN A said she had forgotten to get oxygen orders for Resident #12 and #22 before she clocked out for the day on 05/12/25. LVN A said both Residents were on Oxygen for diagnosis of shortness of breath. LVN A said all nurses were responsible for making sure orders are obtained for oxygen administration and residents on oxygen without physician orders are at risk of not receiving the correct liters of oxygen. 3. Record review of the face sheet dated 05/12/25 indicated Resident #210 was admitted on [DATE] and was [AGE] years old. His diagnoses included diabetes, high blood pressure and third-degree burns. Record review of the admission MDS assessment dated [DATE] indicated Resident #210 MDS was not completed on 05/15/25, not due at that time of the record review. Record review of the care plan dated 05/08/25 indicated Resident #210 received oxygen therapy related to shortness of breath. The interventions included checking O2 saturations & provide respiratory treatments as ordered. Observe for the resident for sign/symptoms of cyanosis, hypoxia, and oxygen toxicity in relation to oxygen therapy. The signs & symptoms to observe for: blue tone to the skin and mucous membranes, rapid breathing, rapid pulse rate, restlessness, confusion, tracheal irritation, difficulty breathing, slow, & shallow rate of breathing. Notify physician upon observation. The oxygen settings were O2 at 3 liters via nasal cannula per physician order. Record review of the physician's orders dated 05/08/25 indicated an order for O2 at 3 LPM per concentrator per nasal cannula. During an observation and interview on 05/13/25 at 11:20 a.m., Resident #210's concentrator setting indicated infusing at the rate of 5 LPM per concentrator and he was in his bed with the oxygen nasal cannula on. LVN A was outside the room in the hall. The wound nurse was coming out of Resident #210's room; she verified the concentrator was set on 5 LPM but was unsure what he had ordered. LVN A said Resident #210 order indicated 3 LPM via concentrator per nasal cannula. LVN A adjusted oxygen setting to 3 LPM. During an interview on 05/13/25 at 2:00 p.m., the DON said the nurses should follow the physician orders with oxygen therapy. She said if too much oxygen was given that could depress the respiration. She said the nurses were responsible for checking the O2 settings and to follow the physician orders. During an interview on 05/14/25 at 8:00 a.m., the Administrator said her expectation was for the nurses to follow the physician's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record Review of Resident #259's face sheet dated 10/12/25, indicated she was a [AGE] year-old female readmitted on [DATE] with diagnoses of respiratory failure (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide resulting in dangerously low oxygen levels in the blood), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and heart failure (condition in which the heart does not pump blood as well as it should). Record Review of Resident #259's most recent quarterly MDS assessment dated [DATE] indicated she had a BIMS score of 5 which indicated severe cognitive impairment. The assessment indicated medical diagnoses of respiratory failure, chronic obstructive pulmonary disease and heart failure and received oxygen therapy on admission continuously and during the last 14 days while a resident in the facility. Record Review of Resident #259's care plan revised 05/13/25 indicated she received oxygen therapy related to chronic obstructive pulmonary disease with interventions including oxygen setting at 2 liters per minute per nasal canula per physician order. Record Review of Resident #259's care plan revised 05/13/25 indicated she received oxygen therapy related to chronic obstructive pulmonary disease with interventions including oxygen setting at 2 liters per minute per nasal canula per physician order. Record Review of Resident #259's Physicians Order Summary dated 05/12/25 indicated she was prescribed oxygen at 2 liters per minute by nasal canula continuously with an order date of 02/19/25. During an observation on 05/12/25 at 09:00 a.m., Resident #259 was lying in bed with oxygen per nasal canula set at 2 liters/ minute to an oxygen concentrator with a black concentrator filter. The oxygen concentrator filter was covered with a light gray powdery substance. Resident #259 said she wears her oxygen all the time. During an observation on 05/14/25 at 08:30 a.m., Resident #259 was lying in bed with oxygen per nasal canula set at 2 liters/ minute to an oxygen concentrator with a black concentrator filter. The oxygen concentrator filter was covered with a light gray powdery substance. Resident #259 said she wears her oxygen all the time. During an observation and interview on 05/14/25 at 8:30 a.m., LVN B said she was providing care for Resident #259 today. She said the filter on Resident #259's oxygen concentrator was dirty and should have been cleaned when the oxygen tubing was changed on 05/12/25. LVN B said maintenance was responsible for cleaning oxygen filters when servicing the concentrators and the night nurse that changed the oxygen tubing should be responsible for cleaning the oxygen concentrator filter. She said the nurses providing care for the residents were the back up and cleaned oxygen concentrator filters as needed. She said it was possibly overlooked but she would clean it now. LVN B said she was in-serviced to clean the oxygen concentrator filters as needed when visibly soiled. She said the resident risk was infection or the oxygen not properly traveling through the oxygen tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/14/25 at 9:31 a.m., the DON said the night nurse was responsible for changing the oxygen tubing and checking the humidifier bottles (oxygen can be drying to your nose so some patients use a humidifier bottle to moisten the oxygen you breath) weekly and ensuring oxygen concentrator filters were cleaned as needed. She said the ADON was the back up and checked the oxygen concentrator filters every Monday. The DON said Resident #259's oxygen concentrator filter may have been overlooked when LVN C changed the oxygen tubing and humidifier bottle. She said the staff were in-serviced on 11/13/24 on respiratory training and to ensure oxygen concentrator filters were cleaned when visible soiled. The DON said there was no resident risk of an oxygen concentrator filter being dirty, if the air flow was obstructed the concentrator would alarm and it was not alarming. She said her expectation was oxygen concentrator filters checked weekly when the oxygen tubing was changed and if visibly soiled cleaned or changed. During an interview on 05/14/25 at 10:11 a.m., the Administrator said the night nurse that changed the oxygen tubing was responsible for ensuring the oxygen concentrator filters were clean and the ADON was the back up. She said all the nurses were educated on ensuring oxygen concentrator filters were clean. She said Resident #259's oxygen concentrator filter was possibly overlooked. The Administrator said there was no resident risk for oxygen concentrators with dirty filters. She said if the oxygen concentrator machine was not receiving proper airflow an alarm would sound if it needed to be addressed and Resident #259's oxygen concentrator was not alarming. She said her expectation was all oxygen concentrator filters were cleaned as needed. During a phone interview on 05/14/25 at 12:09 p.m., the ADON said she made rounds on Resident #259 on Monday, 05/12/25 and Resident #259's oxygen concentrator filter was not dirty, and she was unsure why the oxygen concentrator filter was on 05/14/25. The ADON said the oxygen concentrator filter was a grey/ charcoal color. The ADON said Resident #259 was a recent readmission from the hospital and was given a concentrator that was serviced with a clean filter. She said the night nurse that checked the oxygen humidifier bottle and changed the tubing was responsible for ensuring the oxygen concentrator filter was cleaned. The ADON said she was the back up and checked every Monday to ensure the oxygen concentrator filters were clean. She said all the nurses were in-serviced recently on cleaning oxygen concentrator filters. The ADON said the resident risk of a dirty oxygen concentrator filter was respiratory infection. Unable to interview LVN C, the night nurse that checked Resident #259's oxygen concentrator and changed the tubing on 5/12/25, due to no returned phone message. Record review of a facility in-service dated 11/13/24, titled, Respiratory Training indicated addressed, O2 devises . O2 concentrators Record Review of a facility policy revised 2023, titled, Oxygen Concentrator indicated, .The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators. a. Follow manufacturer recommendations for the frequency of cleaning filters and servicing the device. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated Oxygen Administration policy indicated Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such cases, oxygen is administered, and orders are obtained as soon as practicable when the situation is under control.4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessments and orders.5. a. Follow manufacturer recommendations for the frequency of cleaning equipment filters. 33460 41057

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33460 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure all staff wore hair restraints and restrained all of their hair while plating the food. (05/12/25) This failure could place residents who ate meals prepared in the kitchen at risk of foodborne illnesses. Findings included: During observation on 05/12/25 at 7:50 a.m., the DM was in the kitchen. The DM walked by the stove and by the food prepping tables. The DM operated the dish machine. There was a 2 inches wide area on each side of her neck of unrestrained hair approximately 3 to 4 inches long. During an interview and observation on 05/12/25 at 12:27 p.m., the kitchen staff was serving food for lunch in the dining room from steam table and soup cooker. The DM had a 2-inch-wide area on each side of her neck of unrestrained hair approximately 3 to 4 inches long and she was placing the soup in the bowls. [NAME] C was plating from the steam table the 1 inch to 1 1/2-inches of unrestrained hair on top of her hair which extended from her right ear to the left ear. A long braid along the left side of her face was out of the hair net approximately 4 inches long. DM said all hair should be restrained while serving. [NAME] C and the DM went and secured their hair and washed their hands, after surveyor intervention. The DM said she was responsible for ensuring the staff secured their hair. She said a hair could fall in the food if not secured. During an interview on 05/14/25 at 8:00 a.m., the Administrator said her expectation was for anyone serving food or in the kitchen to wear hair nets. Record review of the undated Dietary Employee Personal Hygiene policy indicated It is the policy of this facility to utilize the following as guidelines for employee personal hygiene to prevent contamination of food by foodservice employees. 4. a. Food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints and clothing that covers body hair, that are designed and worn effectively keep their hair from contacting exposed FOOD, . Record review of the FDA food code dated 2022 indicated . Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (1) Wearing outer garments suitable to the operation (4) Removing all unsecured jewelry (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints.