

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: 455561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 3 Residents (Resident #16 and Resident #5) reviewed for catheter care. The facility failed to assess complications and their causes and maintain a record of any catheter (thin, flexible tube inserted into the body to drain fluids) related problems for Resident #16. The facility failed to assess and ensure appropriate treatment and services were provided including reporting and maintaining a record of any catheter related problems for Resident #5. These failures could place residents who require indwelling catheters at risk for catheter blockage, fistula (abnormal tunnel connecting two body parts) formation, or infection. Findings included: Record review of Resident #16's face sheet, dated 07/07/26, indicated a [AGE] year-old female with an admission date of 02/04/26. Her active diagnoses included neuromuscular dysfunction of the bladder (disruption between the nervous system and the urinary tract), aphagia following a stroke (impairs ability to speak, write, and understand both spoken and written language), and a pressure ulcer (localized soft tissue injuries) of the sacral (bone at the base of the spine) region. Record review of Resident #16's Quarterly MDS assessment, dated 05/08/26, indicated the resident was rarely/never understood and had a BIMS assessment that could not be completed. She was dependent on staff for toileting, bed mobility, and total assistance with bathing. The section bladder and bowel reflected the resident had an indwelling catheter. The active diagnosis section reflected the resident had a neurogenic bladder (disruption between the nervous system and the urinary tract). Record review of Resident #16's Undated care plan, indicated, .The resident has (indwelling foley Catheter: Neurogenic bladder.02/09/2026. The resident will be/remain free from catheter-related trauma through review date. Change Drainage Bag PRN based on clinical indications such as infection, obstruction, or when the closed system is compromised OR per physician's order. Document and notify physician for s/sx of pain/discomfort of catheter, urination, and/or frequency. Record review of Resident #16's order summary, dated 07/07/26, indicated, Urinary Catheter (Indwelling) Catheter Care Q shift and PRN every shift for Catheter Care Empty drain bag & provide peri-care. Notify MD of abnormalities (unusual urine appearance, burning, pain, feeling of full bladder). Urinary Catheter: Change indwelling catheter and Drainage Bag scheduled and PRN due to clinical indications of infection (sediment, foul odor, dark in color), obstruction (slow drainage), or when the closed system is compromised. and every 30 days as needed for Catheter Care. Record review of Resident #16's order summary (after intervention), dated 07/07/26, reflected a new order of .Urinalysis (UTI PCR Panel Reflex - checks for urinary tract infection) ** SENT to Lab 7/7/2026 10:26 AM. Record review of Resident #16's June Administration Record, dated 07/09/26, indicated the urinary catheter 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
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drainage bag were changed on 06/26/26. Record review of Resident #16's progress notes, dated from 06/01/2026 to 07/07/26, did not indicate any notes of an assessment including sediment, any notifications to a doctor, or any other relevant changes or treatments for the indwelling catheter. During an observation on 07/07/26 at 08:45 a.m., Resident #16 was asleep in bed (not interview able). The indwelling catheter bag was hanging from the side of the bed with a privacy cover and below her bladder. The catheter was observed and urine had a large amount of sediment throughout the catheter tubing leading to the drainage bag. During an observation and interview with LVN C on 07/07/26 at 09:34 a.m., she stated the process followed when sediment was found in an indwelling catheter was to notify the doctor, check for output (to ensure no blockage), and change the catheter if needed and if there was an order. LVN C stated, I don't normally work this hall but indicated she was responsible for Resident #16's care 07/07/26. When asked about the indwelling catheter sediment and if anything had been done for Resident #16. LVN C proceeded to pull up Resident #16's chart and stated the indwelling catheter was last changed on 06/26/26 but was unable to say why it was changed. She stated there was an order to be changed as needed. LVN C stated if the doctor was contacted or if there was an assessment that noted sediment, it should have been documented in the progress notes. LVN C stated her assessment of Resident #16 did not indicate abnormal signs or symptoms. She stated the residents abdomen was soft, the urine was free flowing, and the catheter was emptied this morning. She stated the risk of not contacting the doctor or not addressing sediment in the indwelling catheter was it could cause a blockage (in the catheter tubing) or infection. During an interview on 07/07/26 at 9:53 a.m., the ADON/Infection Preventionist stated CNAs should notice changes in urine and notify the nurse. The nurse should contact the doctor for the tubing to be flushed and/or to change the indwelling catheter and bag, and/or for a urine analysis (urine sample) to be completed. She stated there were orders for some residents that included scheduled changes or as needed changes. If there were orders already in place, sometimes they changed them and then notified the doctor. She (the ADON) expected to be notified as well. She stated nurses should be looking for signs of infection when observing the indwelling catheters. The sediment and notification of the doctor should be documented under progress notes. She stated she did not know of any residents' who currently had sediment in their indwelling catheter tubing. She stated she checked catheters yesterday, but not on Resident #16's hallway. She said the potential risk for not contacting the doctor or addressing sediment in the urine was infection. During an observation on 07/07/26 at 10:03 a.m., the ADON/Infection Preventionist observed the indwelling catheter tubing and confirmed there was sediment. She said she would need to contact the doctor, for urinary analysis (urine sample). Record review of Resident #5's face sheet, dated 07/07/26, indicated an [AGE] year-old female with an admission date of 12/08/2025. Her active diagnoses included neuromuscular dysfunction of the bladder (disruption between the nervous system and the urinary tract), aphagia following a stroke (impairs ability to speak, write, and understand both spoken and written language). Record review of Resident #5's Quarterly MDS assessment, dated 06/02/2026 indicated the resident was usually understood and others usually understood her. Resident #5 had a BIMS score of 06, which indicated she had severe cognitive impairment, suggesting significant difficulties with memory, orientation, and thinking skills. She was dependent on staff for toileting, bed mobility, and total assistance with bathing. The section bladder and bowel reflected the resident had an indwelling catheter. The active diagnosis section reflected the resident had a neurogenic bladder (disruption between the nervous system and the urinary tract). Record review of Resident #5s undated care plan, indicated a focus for an indwelling foley catheter Indwelling catheter: Neuromuscular dysfunction of bladder (nerve damage disrupts communication between the brain, spinal cord, and bladder, leading to urinary control (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problems.) initiation date: 03/26/2026. List goal stated: The resident will be/remain free from catheter-related trauma through review date. Listed interventions indicated Position catheter bag and maintain tubing below the level of the bladder, make sure tubing is secured. Document and notify physician for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Record review of Resident#5's order summary, dated 07/07/26, indicated Urinary Catheter (Indwelling): Urinary Catheter: Indwelling Catheter Care Q shift and PRN (as needed). Urinary Catheter: Indwelling Catheter Care Q shift and PRN every shift for Catheter Care Empty drain bag and provide peri-care (incontinent care). Position catheter bag and tubing below level of the bladder, check tubing is free of kinks and securement device in place. Notify MD of abnormalities (unusual urine appearance, burning, pain, feeling of full bladder). Catheter Care Q shift and PRN every shift for Catheter Care Empty drain bag & provide peri-care. Notify MD of abnormalities (unusual urine appearance, burning, pain, feeling of full bladder). Urinary Catheter: Change indwelling catheter and Drainage Bag scheduled and PRN due to clinical indications of infection (sediment, foul odor, dark in color), obstruction (slow drainage), or when the closed system is compromised. and every 30 days as needed for Catheter Care. Record review of Resident #5's order summary indicated a new order (after surveyor intervention) dated 07/07/26, indicated a new order of .Urinalysis (UTI PCR Panel Reflex - checks for urinary tract infection) ** SENT to Lab 7/7/2026 10:23 AM. Record review of Resident #5's June Administration Record, dated 07/09/2026, indicated the urinary catheter and drainage bag were changed on 07/03/2026. Record review of Resident #5's progress notes, dated from 06/07/2026 to 07/07/2026 indicated there were no notes related to her foley catheter, assessments, sediment, nor any notifications to the physician, or any other relevant changes or treatments for the indwelling catheter. During an observation on 07/06/2026 at 9:35 a.m., Resident #5' s indwelling catheter had thick white sediment (stationary) along with medium yellow color urine in catheter tubing. During an observation on 07/07/2026 at 9:15 a.m., Resident #5's indwelling catheter had (an increased amount of from 07/06/2026) thick white sediment (stationary) along with medium yellow color urine in catheter tubing. During an observation and interview on 07/07/2026 at 9:20 a.m., with LVN F. She said she did not look at nor assess Resident #5's indwelling foley catheter. She said usually she did, but she did not because she was busy helping other residents. She said after looking at it she was going to immediately notify the physician to ensure Resident #5 does not have a urinary tract infection. She said the potential risk to Resident #5 was her having a urinary tract infection and leading to sepsis. During an observation and interview on 07/07/2026 at 9:45 a.m., with the DON and ADON (also is the Infection Preventionist). The DON said she was not made aware of the condition of Resident #5's indwelling catheter. She said her expectation was for the nurses to follow the facility's catheter policy and assess residents' catheters to ensure they were free of thick white sediment to reduce the potential risk of infection to residents. The ADON said she saw Resident #5's catheter on 07/06/2026 but did not look at the tubing. I was just making sure it was empty. She said Resident #5's catheter should have been assessed and reported to the physician so a urinary analysis could have been ordered due to the amount of white sediment inside her catheter tubing. During an interview on 07/08/2026 at 1:50p.m., with the Administrator Designee, she said she expected staff to follow facility procedure and policy related to indwelling catheter assessment, and ensure proper/ appropriate treatment, and services were provided for residents with indwelling catheters. She said if the indwelling catheter facility policies were not followed then it could potentially place residents at risk for urinary tract infections. Record review of the facility policy titled, Catheter Care, dated (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February 2023, indicated, . It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.Document care and report any concerns noted to the nurse on duty. There were no other catheter policies available that covered catheter assessments. Record review of the facility policy titled, Notification of Changes, dated February 2023, indicated, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include:. Circumstances that require a need to alter treatment. This may include: New treatment.Discontinuation of current treatment due to: Adverse consequences. Acute condition. Exacerbation of a chronic condition.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 6.45%, based on two errors out of 31 opportunities, which involved 2 of 7 residents (Resident #60, and #66) and 2 of 4 staff (LVN A, and RN B) reviewed for medication error., in that: 1. The facility failed to ensure LVN A did not administer an incorrect dose of Calcium to Resident #66 on 07/07/2026 during a medication pass. 2. The facility failed to ensure RN B did not administer a dose of sliding scale Humalog insulin (used to treat diabetes) from an insulin pen labeled do not use after 06/29/2026 on 07/07/2026, to Resident #60 during a medication pass. These failures could place residents at risk for inaccurate drug administration resulting which could result in decline in health and decreased quality of life. Findings included: 1. Record review of Resident #66's admission Record, for Resident #66 dated 07/08/2026, indicated she an [AGE] year-old female who admitted to the facility on [DATE]. Resident #66 had and was [AGE] years old with diagnoses of which included right femur fracture with a joint replacement, rhabdomyolysis (breakdown of muscle tissue that releases a damaging protein into the blood), and metabolic encephalopathy (another health condition, such as diabetes, liver disease, kidney failure, or heart failure, makes it hard for the brain to work). Record review of Resident #66's admission MDS Assessment, for Resident #66 dated 06/30/2026, indicated she had moderate impairment in thinking with a BIMS score of 11. Resident #66 had and a surgical procedure of to repair fractures of the pelvis, hip, knee, or ankle (not foot). Record review of Resident #66's care plan initiated on 06/25/2026 indicated she had pain related to fractured femur and impaired cognitive function related to metabolic encephalopathy with interventions to administer medications as ordered by doctor. Record review of Resident #66's active physician orders dated 07/08/2026, indicated an order for Calcium 600mg give 1200 mg by mouth in the morning for vitamin supplement. Record review of Resident #66's MAR for July 2026 indicated Calcium 600mg tablet give 1200 mg by mouth was scheduled every morning. During an observation of medication pass on 07/07/2026 at 8:45 a.m. LVN A administered Calcium 600mg 1 tablet from facility stock Calcium bottle on the medication cart. During a record review and interview on 07/08/2026 at 7:30 a.m., LVN A acknowledged she had administered an incorrect dose of Calcium to Resident #66 during medication pass on 07/07/2026 at 8:45 a.m. Resident #66's MAR for July 2026 indicated Calcium 600mg tablet give 1200 mg by mouth every morning, LVN A said she should have given 2 tablets of Calcium 600mg totaling the 1200 mg and she only administer one 600 mg tablet during the medication pass. She said Calcium was used to build and maintain strong bones and with Resident #66's recent fracture was prescribed for bone strength. LVN A said not administering the correct dose of Calcium could cause a decrease in calcium level, decrease bone strength if calcium was not received through prescribed diet. 2. Record review of Resident #60's admission Record, dated 07/08/2026, indicated he readmitted to the facility on [DATE]. Resident #60 was [AGE] years old. Resident #60 had diagnoses which included dementia (a decline in mental ability that can interfere with daily life), and diabetes mellitus (chronic condition in which the pancreas produces little or no insulin). Record review of Resident #60's Quarterly MDS Assessment, dated 06/30/2026, indicated he did not have any impairment in thinking with a BIMS score of 15. During the seven look back period he received insulin injections. Record review of Resident #60's care plan, revised on 06/05/2026, indicated he had physician orders for insulin related to diabetes mellitus with interventions to give diabetic medications as ordered by a doctor. Record review of Resident #60's active physician orders, dated 07/08/2026, indicated an order for Humalog (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if blood sugar is 61 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+= 12 units Re-check BS in 15 minutes. If it is still greater than 401, call MD, subcutaneously before meals and at bedtime for DM. Record review of Resident #60's blood sugars (normal blood sugar ranges before meals range from 70-130): 07/07/2026 9:10 a.m. blood sugar was 155. 07/07/2026 3:45 p.m. blood sugar was 229. 07/07/2026 8:17 p.m. blood sugar was 178. 07/08/2026 7:09 a.m. blood sugar was 163. 07/08/2026 10:25 a.m. blood sugar was 223. During an observation on 07/07/2026 at 3:45 p.m., RN B checked Resident #60's blood sugar and it was 229 mg. RN B said Resident #60 would receive 4 units of Humalog per sliding scale for the 229 mg blood sugar. RN B took the Humalog pen out of the medication cart and dialed it to 4 units. RN B observed Resident #60's Humalog insulin pen and indicated the insulin open dated acknowas on 06/29/2026 and pointed to a label on the pen. RN B entered Resident #60's room and explained to Resident #60 she was administering 4 units of Humalog for his 229 mg blood sugar reading. RN B administered Humalog 4 units SQ to Resident #60's left lower abdomen using proper infection control measures. During an interview and observation on 07/07/2026 at 4:00 p.m., RN B said she used Resident #60's Humalog pen with an added orange label which indicated a use by date of 06/29/2026 while administering Resident #60's sliding scale insulin on 07/07/2026 at 3:45 p.m. RN B said the date on the orange use by date label was the opened date but was on the wrong label but no evidence provided to validate the statement. RN B denied that she had opened or labeled Resident #60's Humalog pen. She said using an expired Humalog pen could be ineffective and the blood sugar could increase. During an observation on 07/07/2026 at 4:00 p.m., the medication cart that was assigned to RN B for the day indicated one Humalog insulin pen with a white label indicating which indicated an opened date which was blank, and an orange label which indicated a use by date of 06/29/2026 prescribed to Resident #60. During an interview and observation on 07/07/2026 at 4:10 p.m., the ADON and DON said they felt the staff had placed the opened date on the wrong label but were removing Resident #60's current Humalog pen and replacing it with a new Humalog pen with the corrected opened date label to the medication cart. They said that nursing staff should follow the rights of medications that included the right resident, medication, dose and check for expiration or use by dates of each medication administered. They said the pharmacist consultant was at the facility last week to destroy drugs, checked medication carts and rooms, observed a medication pass, and provided the facility with recommendations. They said Resident #60 would be monitored for hypo/hyperglycemia, and blood sugar rechecked after supper/prior to bedtime. During an interview on 07/08/2026 at 12:05 p.m., the ADON said the nurses should be following the 5 R's checklist when administering medications: right resident, right medications, right dose, right route, right time, which also should include checking for expiration or used by date. The ADON said administering expired medication could lessen the effectiveness of the medication, with insulin could cause high or low blood sugars. The ADON said residents' not getting a complete dose of calcium could cause bone density and fragile bones which could lead to fractures if residents were prone to falls. During an interview on 07/08/2026 at 12:15 p.m., the DON said the nurses should be following the 5 R's checklist when administering medications: right resident, right medications, right dose, right route, right time, which also should include checking for expiration or used by date. The DON said the nurse administering the medications should be verifying the use by date and expiration date and pharmacy consultant checks for expiration dates during the monthly audits. The DON said administering expired medication could lessen the effectiveness of the medication, with insulin could cause high or low blood sugars. The DON said Resident #60 was monitored and blood sugar rechecked the evening of 07/07/2026 with no adverse (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effects indicated. The DON said she replaced Resident #60's Humalog pen immediately after identified issue and began training nursing staff on insulin pen administration, which included correctly labeling when opening (add date to white label) and use by date (add date to orange label). The DON said Resident #60's MD was notified of the incident and agreed with suggested interventions of monitoring, rechecking blood sugar and discard current Humalog pen and start using new Humalog pen. She said Resident #60's blood sugars were monitored and no ill effects identified. She said residents' not getting the complete dose of calcium could cause low calcium levels, fragile bones health which could lead to fractures if residents were prone to falls. During an interview on 07/08/26 at 1:35 p.m., the designee Administrator said she expected the staff to be compliant with the policies regarding proper medication administration. The Administrator said medications should verify the correct medicine, dosage, the right resident, medication expiration or use by date, and should check to make sure the order was correct before administering any medicine. She said the nurse called and notified everyone including the physician and replaced Resident #60's Humalog pen immediately and monitored him for any ill effects. She said Resident #60's blood sugars were monitored and no ill effects identified. She said omitting medications or administering expired medications could result in medication ineffectiveness. Record review of personnel files indicated LVN A and RN B had training and skilled check offs on medication administration both were satisfactory with medication administration. Record review of the facility's policy titled Insulin Pen indicated, .Policy Explanation and Compliance Guidelines: . 2. Insulin pens must be clearly labeled with resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. 8. Once opened, clearly label insulin pens may be stored at room temperature in a locked medication care. Insulin pens do not require refrigeration after opening. 9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation Record review of the facility's policy titled Medication Administration indicated .Policy Explanation and Compliance Guidelines: .10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation 11. Review MAR to identify medication to be administered.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 3 medication carts (Nurse Back of Hall 200) reviewed for medication storage. The facility failed to ensure medications were not stored on top of the medication cart. This failure could place residents at risk of misappropriation of medications, adverse reactions by ingesting medication that did not belong to them, and not receiving therapeutic effects of medication. Findings included: During an observation and interview on 07/07/26 at 8:15 a.m., LVN A pulled the medication cart to the doorway of a resident's room, locked the cart, locked the electronic medical record and proceeded to walk away, going into the nurse station room located (approximately 40 feet away from the medication cart); leaving an topical pain patch medication on top of the cart and out of her visual sight. The medication cart was unattended during this time and a resident in a wheelchair was self-propelling his wheelchair next to the cart. Multiple staff members walked passed the cart and attended to a resident. At 8:18 a.m., LVN A returned to the medication cart and said she left the cart to get a pair of scissors from the nurse's station to open the topical pain patch packaging. During an interview on 07/08/26 at 8:45 a.m., LVN A stated she should not have left the topical pain patch unattended on the medication cart. LVN A said she should have taken the topical pain patch with her to the nurses' station or placed it back in the medication cart while she went to get a pair of scissors. LVN A said the topical pain patch was not in her view when she left to go to the nurse station. LVN A stated that the topical pain patch was Lidocaine Patch 4 % (topical pain patch). LVN A said she should not have left the medication on top of the medication cart unattended because someone could have taken the medication and it could have caused them to become sick. LVN A said she was trained in medication storage, use of medication carts, and to keep medications locked up when not in use. LVN A said she just got nervous and forgot. During an interview on 07/08/26 at 12:01 p.m., the ADON said the nurses needed to always maintain a view of the medication cart and never walk away from the cart with medications left on top for the safety of the residents, because it risked contamination and someone could come and take the medication off the cart. The ADON said she was not sure why this occurred. The ADON stated nurses were trained on hire and as needed, on the use of medication carts, medication storage and security. During an interview on 07/08/26 at 12:10 p.m., the DON said the nurses were responsible for keeping the medication carts locked and the medications secure. The DON said medications should not be left unattended on the medication cart. The DON said an adverse outcome could be a resident or other staff member could obtain the medication off the cart and cause missing medication or unauthorized access or use of the medication. During an interview on 07/08/26 at 1:30 p.m., the designee Administrator said she expected the staff to be compliant with the policies regarding proper medication storage. The Administrator said medications should never be left on top of a medication cart unattended because from a safety perspective, someone could come along and take it. A record review of the facility's, undated, Policy, titled Medication Storage included that: .Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and (continued on next page)		

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

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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 07/08/2026
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.		

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 07/08/2026
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain 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 for one of 6 residents (Resident #68) reviewed for infection control. The facility failed to ensure CNA D and CNA E wore a gown during high contact activities (bed bath) for Resident #68, who had enhanced barrier precautions in place. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings include: Record review of Resident #68's admission record, dated 07/08/2026, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #68 had a diagnosis which included pressure ulcers (localized skin and soft tissue injuries). Record review of Resident #68's physician orders, dated July 2026, indicated she was on enhanced barrier precautions due to wounds, with the start date of 06/30/2026. Record review of Resident #68's care plan, dated 06/30/2026, indicated she was on enhanced barrier precautions. The interventions included enhanced barrier precautions that were necessary during high-contact care: dressing; bathing; transferring; providing hygiene; changing linens, changing briefs or assisting with toileting; device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes; Wound care: any skin opening requiring a dressing. Record review of Resident #68's admission MDS assessment, dated 07/06/2026, indicated Resident #68's BIMS was which indicated severely impaired with cognition. Resident #68 had 4 unstageable (full thickness tissue loss where wound bed is covered by dead tissue) pressure ulcers. She was dependent on 1-2 staff for bathing and grooming. During an observation on 07/07/2026 at 8:30 a.m., CNA D and CNA E were bed bathing Resident #68 and were not wearing gowns. The CNAs touched Resident #68's body with their arms and their clothes touched her linen as they turned and repositioned Resident #68 during her bed bath. During an interview on 07/07/2026 at 9:15 a.m., CNA D and CNA E said they did not think Resident #68 required enhanced barrier precautions. Observation of Resident #68's room indicated the enhanced barrier sign was posted on the wall by the door of the room. There was PPE hanging on the closet door. CNA E said she was trained in infection control about a year ago. During an interview on 07/07/2026 at 9:53 a.m., the ADON / ICP, and the DON were in their office. The ADON/ICP said the CNAs should have worn gowns and gloves to prevent infections for the residents. The DON said Resident #68 was on enhanced barrier precautions. The DON said her expectation was for the CNAs to wear gowns and gloves when they performed bed baths for residents who were on enhanced barrier precautions. During an interview on 07/08/26 at 1:50 p.m., the designee Administrator said she expected the staff to follow their policies on enhanced barrier precautions. She said with enhanced barrier precautions the staff are to wear gown and gloves when providing close contact care to prevent spreading germs. Record review of personnel files indicated RN F, CNA D, and CNA E did have training on infection control which included enhanced barrier precautions. Record review of the Enhanced Barrier Precautions, dated 2025, indicated Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 2. Initiation of Enhanced Barrier Precautions. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: 1 Wounds (chronic wounds such as pressure ulcers. 3 Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside the room. b. PPE for enhanced barrier precautions is only necessary when performing high contact care activities . 4. High-contact resident care activities include. b. bathing .		