

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2024
NAME OF PROVIDER OR SUPPLIER  Spindletop Hill Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1020 S 23rd St 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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204</b></p> <p>Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 1 of 4 residents (Resident #360) reviewed for baseline care plans.</p> <p>The facility failed to ensure Resident #360's baseline care plan included instructions to address his admission diagnoses and physician orders within 48 hours of admission.</p> <p>This failure could place newly admitted residents at risk of receiving inadequate care and services.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 05/22/2024 and physician orders dated 05/15/2024 indicated Resident #360 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included pneumonia (infection of the lungs), Covid-19, dehydration (dangerous loss of body fluids), Parkinson's Disease (a disease of the central nervous system that affects movement), dysphagia (difficulty swallowing), generalized weakness, and vitamin deficiency.</p> <p>Record review of the hospital records dated 05/08/24 indicated Resident #360 was in the hospital for Covid 19, pneumonia, and dehydration. He discharged home and returned to the hospital approximately 5 days later and was admitted with failure to thrive and described as frail appearing and malnourished. He was noted to have a noted decline and was diagnosed with dehydration and pneumonia. Hospital records indicated he weighed 130 pounds. Further review of the hospital records indicated resident had a medical history of cardiac issues including hypertension (high blood pressure), coronary artery disease (damage or disease in the heart's major blood vessels), atrial fibrillation (an irregular heartbeat causing poor blood flow), and Diabetes II (a condition wherein the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of a behavior consultant report dated 05/10/2024 indicated Resident #360 was diagnosed with adjustment disorder with mixed depression and anxiety (a group of symptoms that can occur after a person experiences a stressful event or life change).</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician orders dated 05/22/2024 indicated orders, written on 05/15/2024, to obtain Resident #360's weight and height on admission and then weigh him weekly times 4 weeks and then monthly and as needed thereafter. The physician orders also included directions for Resident #360 to be evaluated and treated as indicated by a Registered Dietician, physical therapist, speech therapist, and an occupational therapist.</p> <p>Review of Resident #360's admission Fall Risk assessment dated [DATE] indicated he was at a high risk for falls and needed assistance with ambulation and toileting.</p> <p>Review of a Resident #360's Pressure Ulcer Risk assessment dated [DATE] indicated he was at risk for pressure ulcers.</p> <p>Review of a Resident #360's Pain assessment dated [DATE] indicated Resident #360 had a history of low back pain.</p> <p>Review of an untitled care plan for Resident #360 and dated 05/15/2024 identified 2 (two) concerns: his cardiopulmonary resuscitation status and a dependency on staff to meet socialization and activity needs. The care plan did not provide instructions specific to Resident #360's admitting diagnoses of pneumonia, dehydration, difficulty swallowing, Parkinson's disease, weakness, cardiac issues, diabetes, and adjustment disorder. The care plan did not address physician orders for monitoring weight nor did the care plan address Resident #360's risk for falls, ambulation needs, and toileting needs. The care plan did not address any needs related to the orders for speech, occupational, and physical therapies nor dietary needs. The care plan did not address any of the risks assessment findings for falls, pressure ulcers, nor pain.</p> <p>During an interview with the DON on 05/22/2024 at 05:03 PM, she said she was responsible for ensuring the Baseline Care Plan was completed. She said the purpose of the Baseline Care Plan was to provide directions for caring for a resident. She said the Baseline Care Plan provided communication to all disciplines and without it, a resident could be at risk for not receiving the care and services he requires. She said the care plan for Resident #360 that had only the 2 areas of concern was the only care plan he had and there was no other document titled Baseline Care Plan.</p> <p>Record review of the facility's Baseline Care Plan policy dated 10/22/2022 indicated, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.</p> <p>1. The baseline care plan will:</p> <p>a. Be developed within 48 hours of a resident's admission.</p> <p>b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: .</p> <p>i. Initial goals based on admission orders.</p> <p>ii. Physician orders .</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47204</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 4 (Resident #360) residents reviewed for quality of care.</p> <p>The facility failed to obtain a weight on Resident #360 on admission as ordered by the physician.</p> <p>The facility failed to document Resident #360's initial weight in the computerized medical record and communicate it to the Registered Dietician.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 05/22/2024 and physician orders dated 05/15/2024 indicated Resident #360' was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dehydration (dangerous loss of body fluids), dysphagia (difficulty swallowing), generalized weakness, and vitamin deficiency.</p> <p>Record review of the hospital records dated 05/08/24 indicated Resident #360 was in the hospital for Covid 19, pneumonia, and dehydration. He returned to the hospital approximately 5 days later and was admitted with failure to thrive and described as frail appearing and malnourished. He was noted to have a noted decline and was diagnosed with dehydration and pneumonia. Hospital records indicated he weighed 130 pounds. Further review of the hospital records indicated resident had a history of atrial fibrillation, coronary artery disease, hypertension, and diabetes type II.</p> <p>Review of a BIMS assessment dated [DATE] noted Resident #360 had a score of 15 indicating his cognition to be intact.</p> <p>Record review of Resident #360's care plan dated 05/15/2024 did not address any weight concerns, use of an appetite stimulant and thickened liquids, nor dietary recommendations.</p> <p>Record review of Resident #360's physician orders dated 05/22/2024 indicated an order written on 05/15/2024 for the facility to obtain a weight on admission, then weigh him weekly for 4 weeks, and then monthly and as needed thereafter. Other orders dated 05/20/2024 indicated Resident #360 was to begin taking Megace, a medication to increase appetite, and to provide Resident #360 with thickened liquids.</p> <p>Record review of the weights and vital signs records for Resident #360 indicated he had not been weighed on nor since his admission of 05/15/2024.</p> <p>During an interview on 05/22/2024 at 02:26 PM with the DON, she said she did not see a weight in the computer for Resident #360. She said the Restorative Aide was responsible for weighing residents on admission.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/22/2024 at 02:35 PM with the Registered Dietician, she said she did not have a weight for Resident #360 and was waiting on it to complete an evaluation of his dietary needs.</p> <p>During an interview with the Restorative Aide on 05/22/2024 at 02:40 PM, she referred to a paper tablet and indicated Resident #360 was weighed 5 (five) days after admission on 05/20/2024. She pointed to an entry date of 05/20/2024 for a weight of 118.8 pounds for Resident #360. She said she did not always get the weights done when they needed to be done because she was often pulled to the floor when the facility was short-staffed on aides. The Restorative Aide said she did not document weights in the computer. She said the process was for her to weigh residents, write their weights down on paper, and give the paper to the DON who would enter the weights into the residents' computerized charts. At the surveyor's request, the Restorative aide said she would weigh Resident #360 again.</p> <p>During an observation on 05/22/2024 at 02:46 PM, the Restorative Aide and LVN D were observed to weigh Resident #360 using bed scales. Resident #360 was noted to weigh 123.1 pounds.</p> <p>During an interview with Resident #360 on 05/22/2024 at 04:10 PM, he said his usual weight was about 140 pounds. He said he had lost some weight since he had been sick and said he did not have much of an appetite.</p> <p>During an interview on 05/22/2024 at 03:32 PM, the DON said she was responsible for ensuring residents were weighed on admission and as ordered by the physician. She said she expected weights to be done as soon as possible. She said weighing Resident #360 five (5) days after admission was not in compliance with the physician's order for the Resident to be weighed on admission. The DON said the variance in the 05/22/24 weight of 118.8 and the 05/22/24 weight of 123.1 weight could be due to the resident being weighed in a wheelchair the first time and the bed scales the second time. The DON said the failure to obtain weights as ordered and communicate those weights to those who needed the information could result in a delay or absence of care and services needed to prevent weight loss.</p> <p>Record review of the facility's undated policy titled Weight Monitoring indicated .</p> <p>Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended weight loss over a period of time) may indicate a nutritional problem .</p> <p>2. All residents are screened for nutritional risk upon admission . Assessments should include the following information: c. Weight .</p> <p>5. A weight monitoring schedule will be developed upon admission for all residents.</p> <p>a. Weights should be recorded at the time obtained .</p> <p>27140</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41695</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase their range of motion and to prevent further decrease in range of motion and failed to ensure residents with limited mobility received appropriate services, and assistance to maintain or improve mobility in the hands for 1 of 1 residents reviewed for range of motion. (Resident #75)</p> <p>The facility did not place hand rolls and/or positioning devices in Resident #75's right hand to prevent future decline in ROM.</p> <p>This failure could place the resident at risk of not receiving the appropriate care and services to maintain their highest level of well-being.</p> <p>Findings included:</p> <p>Record review of physician's orders dated 05/22/2024 indicated Resident #75 was a [AGE] year-old female admitted [DATE] with diagnoses of contracture of right hand, need assistance with personal care, altered mental status, muscle wasting and atrophy, and unspecified dementia. The orders indicated the resident was to ensure a handroll in place every shift, dated 03/03/2024.</p> <p>Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #75 had a BIMS score of 99 (severe impairment) and had a decrease in ROM to one side of his upper extremities. The MDS assessment did not indicate the resident had behaviors or resisted care.</p> <p>Record review of a care plan for Resident #75 dated 11/07/2022 with target date 04/02/2024 for ADLs addressed resident has contractures of the right hand, but did not address the use of a hand roll.</p> <p>Record review of Resident #75's treatment administration record dated May 2024 indicated the resident received had a handroll in place.</p> <p>During an observation on 05/20/2024 at 10:00 AM, Resident #75 was sitting up in broda chair (a type of wheelchair for long term seating)in the hallway resident had no hand roll in place. The resident's fingers to the right hand were contracted upward towards the bottom of the palm of her hand. The thumb was contracted inward and rested under the contracted fingers and between the third and fourth fingers.</p> <p>During the following observations Resident #75 did not have a handroll in place:</p> <p>5/20/2024 at 12:30 PM while up in dining room</p> <p>5/21/2024 at 9:00 AM in bed</p> <p>5/22/2024 at 9:00 AM up in hallway</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5/22/2024 at 12:28 PM in bed</p> <p>5/22/2024 at 3:00 PM in bed</p> <p>During an interview on 05/22/2024 at 12:59 PM with ADON D, when asked whose responsibility it was to have handrolls in place she said, it is everyone's responsibility to make sure that handrolls are in place.</p> <p>During an interview on 05/22/2024 at 2:00 PM, CNA J was asked to show the surveyor the task on the CNA task board, and it clearly states, Contractures to place hand rolls every shift , She said it was her responsibility and she had not placed any handrolls in place on Resident #75.</p> <p>During an interview 5/22/2024 at 3:00 pm, the DON was asked for a policy on Range of Motion and placement of handroll/splints. The facility did not provide a policy.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41695</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 2 of 2 residents (Resident #44, #89) reviewed for gastrostomy tube management quality of care.</p> <p>The facility failed to ensure Residents #44 and #89 were provided with the correct feeding through gastrostomy tube (g-tube, feeding tube) as ordered per physician.</p> <p>This failure could place residents who received feedings by gastrostomy tube at risk for injury, aspiration into the lungs (fluid or food enter the lungs accidentally), decreased quality of life, hospitalization and decline in health, weight loss and poor wound healing in residents with a g-tube.</p> <p>Findings included:</p> <p>1. Record review of Resident #44's face sheet, dated 05/22/24, indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including cerebral infarction (lack oxygen to the brain causing damage to brain tissue), oropharyngeal dysphagia (inability to swallow food or liquid), and gastrostomy status (a feeding tube that delivers nutrition to your stomach).</p> <p>Record review of Resident #44's MDS assessment dated [DATE], indicated she had unclear speech and was unable to make her understood or understand others. She had short and long-term memory problems and severely impaired cognition. She had a feeding tube used for nutrition.</p> <p>Record review of Resident #44's care plan dated 11/30/22 indicated she required a feeding tube related to dysphagia and interventions included Jevity 1.5 as ordered and to look at physician orders for current feeding orders.</p> <p>Record review of Resident #44's physician orders dated 05/04/23 indicated an enteral feeding order for Jevity 1.5 @ 65ml/hour, Down time 10:00 a.m.-2:00 p.m</p> <p>During an observation on 05/20/24 at 2:00 p.m., Resident #44 was in her room lying in bed. There was tubing with Jevity 1.5 connected to a feeding pump on a pole next to Resident #44's bed. Resident #44's was not connected to her feeding pump and the pump was turned off.</p> <p>During an observation on 05/20/24 at 2:30 p.m., Resident #44 was in her room lying in bed. Resident #44's was not connected to her feeding pump and the pump was turned off.</p> <p>During an observation on 05/20/24 at 3:05 p.m., Resident #44 was in her room lying in bed. Resident #44's was not connected to her feeding pump and the pump was turned off.</p> <p>During an observation on 05/20/24 at 3:10 p.m., LVN S entered Resident #44's room. LVN S connected Resident #44's tubing to her peg tube and resumed her Jevity 1.5 at 65ml/hour. LVN S was not available to be interviewed.</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 - Some</p>	<p>2. Record review of Resident #89's face sheet, dated 05/22/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with readmitted on [DATE] with diagnosis to include Traumatic Subarachnoid Hemorrhage with loss of Consciousness of Unspecified Duration, Dysphagia, subsequent encounter, Chronic Respiratory Failure with Hypoxia, Pedestrian injury in unspecified nontraffic accident, Subsequent encounter, and gastrostomy status (g-tube).</p> <p>Record review of the comprehensive MDS assessment dated [DATE] revealed Resident #89 Weight loss: loss of 5% or more in the last month or loss of 10% or more in last 6 months. The MDS further documented Resident #89's Nutritional Approach While a Resident was feeding tube.</p> <p>Record review of the current care plan for Resident #89, last revised on 05/08/2024, revealed a focus area for: [Resident #89] requires a tube feeding r/t (related to) dx (diagnosis) of dysphagia; Focus: The resident requires tube feeding r/t dysphagia.</p> <p>Record review physicians orders of Resident (#89) dated 4/16/24- Recommend new Enteral feeding order for Jevity 1.5 @ 70 ml/hour x 20 hours with H2O (water) flushes at 25ml/hour x 20hours, Down time 0800am-1200 pm.</p> <p>During the following observations for Resident #89's the feeding pump resident was in bed during all observations:</p> <p>5/20/2024 at 12:00PM feeding pump on alarm: Flow error.</p> <p>5/20/2024 at 1:30 PM feeding pump on alarm: Flow error.</p> <p>5/20/2024 at 2:00 PM feeding pump on alarm: Flow error.</p> <p>5/20/2024 at 3:00 PM feeding pump on alarm: Flow error.</p> <p>5/20/2024 at 3:30 PM feeding pump on alarm: Flow error.</p> <p>5/21/2024 at 12:30 PM feeding pump on alarm: Flow error.</p> <p>5/21/2024 at 1:00 PM feeding pump on alarm: Flow error.</p> <p>5/21/2024 at 1:30 PM feeding pump on alarm: Flow error.</p> <p>5/21/2024 at 5:11 PM feeding pump on alarm: Flow error.</p> <p>5/22/2024 at 12:30 PM No enteral feeding up.</p> <p>5/22/2024 at 12:45 PM No enteral feeding up.</p> <p>5/22/2024 at 1:30 PM no enteral feeding Resident observed being feed orally.</p> <p>5/22/2024 at 2:00 PM feeding pump off and resident said he was hungry.</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 - Some</p>	<p>During an interview and observation on 5/20/2024 at 12:30PM with LVN G revealed that Resident #89's feeding pump was off because he can also have oral feedings., She could not find the order to turn the enteral feeding off, and she said she would have to check with the physician on an order clarification. LVN G said there should be an order to turn enteral feeding off and she did not know what the guidelines to turn feeding off regarding the amount of oral intake the resident consumes.</p> <p>During an interview and observation on 5/21/2024 at 12:30 PM, LVN E revealed that resident #89's feeding pump was off, she had no idea why because she was called in to work the unit, but she will find out why by checking the physicians orders, she said she does know they are trying oral feeding , she could not find the order to turn the enteral feeding off, she said she would have to check with the physician on an order clarification. LVN E said there should be an order to turn enteral feeding off.</p> <p>During an interview and observation on 5/22/2024 at 12:45PM., LVN L revealed that resident #89's feeding pump was off because he can also have oral feedings., she could not find the order to turn the enteral feeding off., she said she would have to check with the physician on an order clarification. LVN L said there should be an order to turn enteral feeding off.</p> <p>During an interview with DON on 5/22/2024 at 4:20 PM the DON stated she was unsure why Resident #89 feeding pump was not infusing accurately. The DON stated maybe the RD had recommending a new dietary order, but she was unable to locate a new order from the RD. The DON stated the nurses are trained to check the feeding pump rate when new bags of formula are hung. The DON stated the potential negative outcome to the residents were weight loss, or it could affect wound healing. The DON was asked for policy on Enteral Feeding. The facility did not provide a policy before exit.</p> <p>37495</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>37495</p> <p>Based on observation, interview, and record review, the facility failed to post Nursing Staffing Data information daily as required for 3 of 4 days (05/17/24, 05/18/24, and 05/19/24) reviewed for nursing services.</p> <p>The facility failed to post the total number of hours worked for licensed nurses and certified nurse aides or the daily census for May 17th, 18th, and 19th of 2024.</p> <p>This failure could cause residents, families, and visitors to be unaware of the facility daily staffing requirements.</p> <p>Findings included:</p> <p>During an observation on 05/20/24 at 8:32 a.m., the staffing sheet posted was dated 05/16/24.</p> <p>During an observation on 05/20/24 at 1:43 p.m., the staffing sheet posted was dated 05/20/24.</p> <p>During an interview on 05/23/24 at 9:43 a.m., CNA R said she was the staffing coordinator. CNA R said she worked Monday through Friday 8:00 a.m. to 5:00 p.m and was responsible for posting the staffing sheet during the week. CNA R said she did not have the staffing sheets for 05/17/24, 05/18/24, and 05/19/24. CNA R said she did not know who was responsible for posting it on the weekend.</p> <p>During an interview on 05/22/24 at 10:08 a.m., the Administrator said CNA R was responsible for posting the staffing sheets during the week and the MOD was responsible for posting them on the weekend. The Administrator said the department heads were scheduled to work a weekend as the MOD.</p> <p>During an interview on 05/22/24 at 10:23 a.m., the BOM said she was the MOD when she worked the weekends. The BOM said she did not know the MOD was responsible for posting the staffing sheets. The BOM said she never posted the staffing sheets on the weekends because she was never told she had to. The BOM said she would have posted the staffing sheets if she had known.</p> <p>During an interview on 05/22/24 at 10:08 a.m., the Administrator said she did not know the staffing sheets were not being posted on the weekends. The Administrator said she expected the staffing to be posted daily so residents and family members could be assured adequate staffing was being provided. The Administrator said she would in-service all the department heads on posting the sheets on the weekends.</p> <p>Record review of the facility's staffing sheets for May 2024 indicated there were no documented staffing sheets on 05/17/24, 05/18/24, and 05/19/24.</p> <p>Record review of the facility's Nurse Staffing Posting Information policy dated 10/24/22 indicated, Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis .2. The facility will post the Nurse Staffing Sheet at the beginning of each shift .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Spindletop Hill Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1020 S 23rd St 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.

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>41695</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>27140</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen observed for kitchen sanitation.</p> <p>Sixteen (16) stainless steel steam table pans were stacked wet on the pan storage rack.</p> <p>Cook T used a paper drying cloth to dry pans that were to air dry.</p> <p>One (1) 3 oz. serving utensil containing dried food debris was placed on the serving line.</p> <p>The dietary kitchen did not consistently provide snacks for residents on the memory unit.</p> <p>Untrained staff on the memory unit made sandwiches from bread, peanut butter and jelly provided by the kitchen.</p> <p>The area where sandwiches were made on the memory unit was not a designated food preparation area. It was not supplied with hairnets, sanitizing solution, and the staff had not completed a food handler certification training.</p> <p>Untrained staff making sandwiches on the memory unit did not label and date the packages containing the food after they were opened.</p> <p>These failures could place residents who ate food from the kitchen at risk of foodborne illness.</p> <p>Findings included:</p> <p>During observations and interviews on 05/20/24 of the kitchen the following was noted:</p> <p>*at 10:27 AM on the wire pan rack the following stainless steel pans were stacked wet: 6-half-size 6 deep; 4-half-size 8 deep; 1-quarter-size 8 deep long; 5 quarter-size 8 deep square. Water was observed pooled in the lips of the pans. The DM said the pans should be left to air dry after being cleaned and sanitized in the 3-compartment sink. She said they should not be stacked wet.</p> <p>*at 10:30 AM the utensil drawer under the prep table by the stove contained food debris in the bottom of the drawer. Dried liquid was apparent on the lip of the drawer. The DM said she would get it cleaned.</p> <p>During an interview on 05/20/24 at 04:00 PM the DM said dietary staff had been inserviced on the 3-compartment sink and air drying of dishes. She provided documentation of the training. She provided the policy on manual cleaning and sanitizing of utensils and portable equipment.</p> <p>During observations and interviews on 05/21/24 of the kitchen the following was noted:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*at 11:35 AM stainless steel pans were observed sitting on the clean side of the 3-compartment sink stacked to air dry. Some of the pans were tilted and some were lying bottom side up. Cook T needed to make room on the drying station to prepare pureed food items and he began removing the pans. He picked up one half size pan and looked at it and said it appeared to be dry and placed it on the pan rack. He picked up the next pan and looked inside and said it appeared dry. It was pointed out to him the outside still had drops of water hanging on the sides. He placed the pan back on the drying station. He went to a closet and returned with paper toweling and proceeded to dry the inside and outside of the pans and placed them on the pan storage rack. The corporate DM told him it was okay to hand dry the pans. When brought to the attention of the DM she stopped him and said the pans must air dry and may not be wiped or dried with any cloth or towel before placing onto the storage rack.</p> <p>*at 12:10 PM the Regional Corporate DM produced a 3 oz. serving utensil to place on the steam table for service. It was noted to have dried food debris in the bowl of the utensil which she did not notice. It was pointed out to the regional DM and she removed the utensil to the 3-compartment sink area to be re-washed and returned to the steam table. It had not been used for any food service.</p> <p>During an observation and interview on 05/20/2024 at 2:16 PM, NA N was observed standing in a small room adjacent to the dining area in the memory care unit. NA N said she was about to make peanut butter and jelly sandwiches for the residents. NA N washed her hands in the sink with a shampoo and body wash solution. NA N was not wearing a hair net or an apron. She put gloves on. NA N did not clean or sanitize the countertop before she spread paper towels on the countertop. NA N spread slices of bread on the paper towels and spread peanut butter on 1/2 of the slice of bread with a disposable spoon. She said she put the amount of peanut butter on the bread she would like on her sandwich. NA N said she had not received any dietary training and did not have a food handler certification. NA N continued to make sandwiches for the residents. She spread jelly on the other 1/2 of the slice of bread and folded the slice of bread, in half. The loaf of bread NA N used to make the sandwiches for the residents did not indicate an initial open use date. A second loaf of bread with approximately 1/3 loaf of the bread remaining in it, also did not indicate an initial open use date. At 2:35 PM, a tray of snacks were delivered to the small room adjacent to the dining area in the memory unit. NA N said she was not going to use the snacks because she had already made the sandwiches. She said the kitchen usually does not bring snacks to the unit. She said the kitchen gave them the bread, peanut butter and jelly to make their own snacks for their residents.</p> <p>During an interview on 05/20/2024 at 3:02 PM, the DM said someone from the memory unit will usually come to the kitchen and request snacks. She said the kitchen provided snacks for the other residents on the other halls of the facility. She did not explain why the memory unit had to request snacks each day. She said she did not know if any staff working on the memory unit had a food handler certification. The DM said she joined the facility in October of 2023, and she recognized that too many sandwiches were being thrown away on the memory unit. She said she decided to provide the unit with bread, peanut butter and jelly and they could make only the sandwiches they needed.</p> <p>During an interview on 05/20/2024 at 3:21 PM, DA O said she provided the memory unit with a snack tray. She said someone from the memory unit came to the kitchen earlier and requested a snack tray. She said she could not remember who the staff person was. She said she last took a tray to the unit on 05/16/2024. She said the kitchen had not been taking snacks before 05/16/2024, because they have peanut butter and jelly on the unit to make their own snacks.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/20/2024 at 3:30 PM LVN M said staff on the memory unit have been making snacks for the residents on the memory unit for approximately 6 months. She said she did not think it was a good idea to have staff on the memory unit make snacks but the decision was not hers to make. LVN M said the kitchen had not been sending snacks to the unit for about 6 months. She said they only did it at that time because of the survey. LVN M said the activity assistant had a food service certification but, she had never made snacks for the residents on the unit.</p> <p>During an interview on 05/21/2024 at 9:00 AM, AA P said she had a food service certification, but she never made snacks on the memory unit, for the residents on the unit. She said when she brought snacks for activities the snacks would be for all the residents in the facility and not just for the memory unit.</p> <p>During an interview on 05/22/2024 at 9:00 AM, the DM said she told her staff to make and send snacks to the memory unit on 05/22/2024. She said she later learned the snacks were never delivered to the unit. She said the memory unit was throwing away a lot of sandwiches and she thought they could just make the sandwiches they needed for their residents. She said the area being used to prepare sandwiches in the memory unit was not a designated kitchen area and was not supplied with the appropriate equipment and sanitizing supplies. She did not know if adequate snacks and sandwiches were provided for the residents on the memory unit. She said she did not make sure the CNAs were trained and received a food handler's certification to be able to prepare food for the residents.</p> <p>During an interview on 05/22/2024 at 9:04 AM, DA Q said she was supposed to take snacks to the memory unit, but she forgot. She said she was busy and she forgot to take the snacks to the unit. She said the snacks were peanut butter and jelly sandwiches, oatmeal cream pies and graham crackers.</p> <p>Review of a facility policy Manual Cleaning and Sanitizing of Utensils and Portable Equipment, dated October 1, 2018, indicated Air dry the utensils or equipment, since wiping can re-contaminate equipment and can remove the sanitizing solution from the surfaces before it has finished working. Make certain all equipment is dry before putting it into storage.</p> <p>Review of the FDA Food Code dated 2013 indicated the following:</p> <p>4-901.11 Equipment and Utensils, Air-Drying Required.</p> <p>After cleaning and SANITIZING, EQUIPMENT and UTENSILS:</p> <p>(A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 .</p> <p>(B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry.</p> <p>Review of the FDA Code dated 2013 indicated the following:</p> <p>4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.</p> <p>(B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility policy: Texture Modified Snacks, Policy Number: 01.011, revised date April 15, 2019. Procedure: 1. Nutrition and Foodservice will provide HS snacks each night for all residents including residents with orders for a puree diet.</p> <p>42190</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204</b></p> <p>Based on observation, interview, and record review, the facility failed to 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 4 of 8 residents (Resident #41, #52, #94, and #97) reviewed for infection control during medication administration and for residents receiving enteral feedings.</p> <p>The facility failed to ensure LVN B used appropriate hand sanitation practices to prevent and/or control the spread of infection during medication administration to Residents # 52, #94, and #97.</p> <p>The facility failed to ensure LVN A obtained a new bottle of formula and tubing after the previous bottle had been left with the end of the tubing open and uncovered for approximately 24 hours.</p> <p>These failures could place residents and staff at risk for cross-contamination and spread of infection.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 05/21/2024 indicated Resident #52 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included osteomyelitis (infection of the bone) and amputation of the right great toe.</p> <p>Record review of a face sheet dated 05/21/2024 indicated Resident #94 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included MRSA (Methicillin Resistant Staphylococcus Aureus) infection and cellulitis of the right lower limb.</p> <p>Record review of a face sheet dated 05/21/2024 indicated Resident #97 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included urinary tract infection and Fournier's gangrene (a rare, rapidly progressive, and potentially fatal infection that affects the genital, anal, scrotal, and perineal region) that had required surgical intervention.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observation of medication administration on 05/21/2024 from 09:15 AM to 09:40 AM, LVN B was observed to push her cart with her hands to the doorway of the room of Residents #52 and #94. LVN A touched several items on top of the medication cart and without sanitizing her hands, she obtained medications from the cart, placed them in a small paper cup, and took them into the room. She placed the cup in Resident #52's hand. Resident #52 poured the cup of medications into her mouth and returned the empty cup to LVN B's hand. LVN B discarded the medication cup and returned to the medication cart where she accessed the computer. After documenting the medication administration, LVN B, without sanitizing her hands, obtained a blood pressure device from the cart and took Resident #94's blood pressure, touching the resident's arm in the process. LVN B returned to the cart, documented the blood pressure in the computer, and without sanitizing her hands, obtained and prepared medications for Resident # 94. She re-entered the room and handed the cup of medications to Resident #94. Resident #94 took the medications and returned the empty cup to LVN B's hand. LVN B discarded the cup, returned to the cart, and pushed the cart to the next room. Without sanitizing her hands, LVN B obtained medications from the cart for Resident #97, placed them in a small paper cup, and took the medications to Resident #97's bedside. She gave him the cup containing medications and he poured them into his mouth. He returned the empty cup to the nurse who took the cup and discarded it. LVN B returned to the cart where she accessed the computer again. LVN B was observed to prepare and administer medications to 3 residents (Residents #52, #94, and #97) without sanitizing her hands before and after medication administration nor between residents.</p> <p>During an interview on 05/21/2024 at 09:42 AM, LVN B said she forgot to perform hand hygiene. She said hand hygiene was important for the prevention and control of infection.</p> <p>During an interview on 05/21/2024 at 11:30 AM, the DON said the staff knew they were supposed to wash their hands before and after tasks and between residents. She said failure to use proper hand sanitization could lead to the transmission of infection from one resident to another and to staff.</p> <p>Record review of the facility's policy titled Medication Administration and dated 10/24/2022 indicated the following:</p> <p>Policy:</p> <p>Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>Policy Explanation and Compliance Guidelines: .</p> <p>4. Wash hands prior to administering medications per facility protocol and product .</p> <p>14. Administer medication as ordered in accordance with manufacturer's specifications.</p> <p>15. Observe resident consumption of medication.</p> <p>16. Wash hands using facility protocol and product.</p> <p>Record review of the facility's policy titled Hand Hygiene and dated 10/24/2022 indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .</p> <p>Record review of a face sheet dated 05/20/2024 indicated Resident #41 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke), ileus (inability of the intestine to contract normally and move waste out of the body), and gastrostomy tube placement (a feeding tube inserted into the stomach for supplying liquid nutrition). An MDS dated [DATE] indicated Resident #41 was rarely understood and was dependent on staff for all activities of daily living.</p> <p>During observation on 05/20/2024 at 11:18 AM, Resident #41 was noted to be lying on her back on a bed low to the floor. A metal pole beside the bed was noted to have a bottle containing approximately 950 milliliters of tan colored liquid hanging on it. The bottle had a label that said the liquid was Osmolite 1.5 (a nutritional formula designed to be administered directly into the gastrointestinal tract via a tube inserted into the stomach). There was a tube draped over the top of the pole with one end of the tube inserted into the bottle and the other end was noted to be uncovered and open to air. The bottle had a date and time of 05/20/2024 05:00 AM written on it. The feeding pump was turned off. Resident # 41 was observed again on 05/20/2024 at 01:35 PM and at 05:00 PM. The tubing inserted into the bottle was noted to be draped over the top of the pole with one end open and exposed. The tubing did not have a covering on the open end to prevent anything from entering the tubing.</p> <p>During an observation on 05/21/2024 at 08:35 AM, Resident #41 was noted to be lying in bed with the feeding pole beside the bed. The bottle of formula with a label saying Osmolite 1.5 and with the same date and time of 05/20/2024 05:00 AM was noted to be connected to the resident and the feeding pump indicated the formula was infusing into Resident #41's stomach at 40 milliliters and hour.</p> <p>During an interview on 05/21/2024 at 10:34 AM, LVN A said the facility had received an order to restart the formula at 09:00 AM on 05/21/2024. She said she was the nurse who restarted the feeding. LVN A said she did not obtain a new bottle of formula. LVN A said she used the same tubing that was attached to the bottle. She said she did not obtain new tubing. She said she should have obtained a new bottle of formula and new tubing since the tubing on the bottle of the formula had not been capped after disconnecting it from the resident on the day before.</p> <p>During an interview with the DON and Nurse Consultant on 05/21/2024 at 10:45 AM, the DON said the facility did not have a policy for enteral feedings. The RN Consultant said the manufacturer's instructions indicated an opened or accessed bottle of Osmolite 1.5 could hang for 48 hours.</p> <p>1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.</p> <p>Record review of the manufacturer's product information sheet indicated a bottle of Osmolite 1.5 formula could hang for up to 48 hours after initial connection. The formula's initial connection was broken when the tube was disconnected from Resident #41. The end of the tubing that was connected to Resident #41 was left open providing an avenue for bacteria, dust, and/or possibly insects to enter the tubing and formula.</p>		