

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 08/06/2024
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115</p> <p>Based on observation, interview, and record review, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 8 residents (Resident #1) reviewed for accuracy of clinical records.</p> <p>LVN A did not document her assessment of Resident #1's in the EHR on 08/02/24 after she was informed Resident #1 was observed biting her right hand. On 08/05/24 Resident #1 was observed with injuries of unknown origin that included a bruise and scratches to the top of her right hand and wrist and edema around her right eye and on her right forehead.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 08/06/24 indicated she was a [AGE] year old female admitted on [DATE] and her diagnoses included dementia (loss of cognitive functioning), muscle wasting and atrophy (decrease in size and wasting of muscle tissue), contracture of muscles, cerebral infarction (stroke), history of falls, repeated falls, and dysphagia (difficulty swallowing).</p> <p>Record review of Resident #1's physician orders dated 04/01/24 indicated Tylenol Extra Strength Oral Tablet 500 mg give 1 tablet every shift for pain.</p> <p>Record review of Resident #1's physician orders dated 04/01/24 indicated Tylenol Extra Strength Oral Tablet 500 mg give 1 tablet every 6 hours as needed for pain.</p> <p>Record review of Resident #1's quarterly MDS dated [DATE] indicated she had unclear speech, was rarely understood or understood others, had severely impaired cognitive skills, and had no exhibited psychosis or behaviors. She had impaired ROM on both sides of upper and lower extremities. She utilized a wheelchair for mobility. She was dependent for all ADLS and mobility.</p> <p>Record review of Resident #1's weekly skin assessment dated [DATE] indicated no abnormal skin areas.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's MAR dated 08/02/24 indicated LVN K administered 1 tablet of Tylenol 500 mg at 6:23 p.m. for pain.</p> <p>Record review of Resident #1 hospice note dated 08/02/24, completed by RN J indicated a call received from facility nurse (LVN A). Resident #1 appeared in pain.</p> <p>Record review of Resident #1's care plan dated 08/05/24 indicated Resident #1 was at risk for impaired skin integrity related to biting the tops of her hands while with therapy on 08/02/24. Interventions included CNAs to monitor skin daily during care and report any signs of skin break down to licensed nurses, conduct weekly skin inspections/examinations weekly and as needed and document findings.</p> <p>Record review of Resident #1's care plan dated 08/05/24 indicated Resident #1 had a knot to the right side of her forehead, fluid pocket to right eyelid, dime sized bruise to top of right wrist and 2 small scratches to top of right wrist. Interventions included hospice to order another wheelchair or per hospice nurse only up for meals. Sent to ER for evaluation and treatment.</p> <p>Record review of Resident #1's weekly skin assessment dated [DATE], completed by the DON, indicated a dime sized bruise to top of right wrist, 2 small scratches 1 x 0.1 to top of right wrist, right eye edema and knot to right side of forehead.</p> <p>Record review of Resident #1's progress note dated 08/05/24 at 7:00 a.m., completed by LVN D indicated hospice CNA H notified LVN D of Resident #1's knot above eyebrow. Hospice CNA H indicated the knot above eyebrow was new. LVN D notified hospice of knot on Resident #1's forehead. Hospice RN I arrived to assess Resident #1.</p> <p>Record review of Resident #1's progress note dated 08/05/24 at 9:05 a.m., completed by the DON, indicated the DON and hospice RN assessed Resident #1. There was a dime sized bruise to top of right hand, 2 small scratches 1 x 0.1 to top of right hand, fluid pocket to right eye and knot to forehead. DON was made aware of area on forehead and observed Resident #1 waiting for breakfast. Resident #1 had her head leaning over onto table where swelling/fluid was on right eye. Resident #1 was repositioned in wheelchair. There was no grimacing or other indicators of pain.</p> <p>Record review of Resident #1's progress note dated 08/05/24 at 9:22 a.m., completed by LVN D, indicated hospice nurse assessed Resident #1 due to a knot above right eyebrow and bruises on right arm. Resident #1 sent to ER via EMS for evaluation. Hospice nurse notified RP.</p> <p>Record review of Resident #1's progress note dated 08/05/24 at 9:34 p.m., completed by LVN G, indicated Resident #1 returned from the ER with no new orders.</p> <p>Record review of Resident #1's hospice note dated 08/05/24, completed by RN I, indicated Resident #1 was sitting up in her wheelchair awake and disoriented. She was not able to make her needs known. No signs or symptoms of distress or discomfort noted. Resident had a hematoma 2.0 cm X 2.0 cm over her right eyebrow. Bruising and abrasion noted to right wrist and forearm. Staff unable to provide information on origin of injuries. Resident #1 sent to hospital for evaluation.</p> <p>Record review of Resident #1's hospital CT record dated 08/05/24 indicated right periorbital (tissues surrounding the orbit of the eye) and forehead soft tissue swelling.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's progress note dated 08/06/24 at 8:29 a.m., completed by the DON, indicated Resident #1 had a small bruise to the top of her right wrist, 2 small scratches to the top of her right wrist and a pocket of fluid to her right eye. No signs or symptoms of pain or discomfort. No knot noted on forehead.</p> <p>During an interview on 08/06/24 at 9:00 a.m., the DON said hospice CNA reported Resident #1 had a dime sized bruise on the top of her right wrist on 08/05/24. There was a pocket of fluid around her right eye and a knot on her right forehead area. She assessed Resident #1 and reported to her RP and hospice. She said the RP did not want Resident #1 sent to hospital until hospice evaluated her. She said hospice evaluated Resident #1 and sent her out for evaluation. She said there was no reported falls. She said Resident #1 had a history of falls. She said as of 08/06/24 there was no actual bruise on Resident #1's forehead. She said there was a pocket of fluid around her right eye. She said she recalled Resident #1 had the right side of her face pressed on the dining table during the breakfast meal on 08/05/24 and that behavior may account for the swelling. She said she assessed Resident #1 on 08/06/24 and could not find a bruise.</p> <p>During an observation on 08/06/24 at 10:00 a.m., Resident #1 was awake and lying in her bed. Her bed was in low position. There was a scoop mattress. There was a fall mat on each side of the bed. Resident #1's right eyelid and under right eye area appeared swollen/puffy. Her right forehead area appeared slightly swollen/puffy. There was a dime size darkened area on the top of her right hand and two small scratches on top of her right wrist. Resident #1 was moving her right leg over the side of the bed. Her right arm was bent at the elbow and her right hand was tucked behind her head. She did not respond to questions. She did not exhibit any signs of pain or agitation.</p> <p>During an interview on 08/06/24 at 10:30 a.m., LVN D said the hospice aide brought Resident #1 to the nurses' station on 08/05/24 at approximately 6:00 a.m She said Resident #1 did not have a knot or a hematoma on her forehead but it did look puffy around her eyebrow. She said the hospice aide was not aware of how the swelling occurred. She said reported the swelling to the DON and hospice.</p> <p>During an interview on 08/06/24 at 11:49 a.m., CNA F said she saw Resident #1 at the nurse station on 08/05/24 at approximately 6:00 a.m. She said she saw there was swelling around Resident #1's right eye. She said she last saw Resident #1 on 08/02/24 and she had no bruising or swelling. She said Resident #1 was not combative with care. She said she was not aware of Resident #1 falling.</p> <p>During an interview on 08/06/24 at 12:08 p.m., CNA E said she completed Resident #1's incontinent care and repositioned her from one side to her other side at approximately 4:45 a.m. on 08/05/24. She said she did not notice any bruising or swelling on Resident #1's face, arms, or right hand from 6:00 p.m. on 08/04/24 through 6:00 a.m. on 08/05/24. She said Resident #1 was not aggressive during care and did not exhibit any signs of pain or agitation. She said Resident #1 had no falls on her shift from 6 p.m. on 08/04/24 through 6:00 a.m. on 08/05/24.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/06/24 at 12:36 p.m., LVN C said she observed Resident #1 on 08/04/24 at approximately 8:00 p.m. but did not examine her or notice a knot on her right forehead, swelling around her right eye, the bruise on the top of her right hand, or the two scratches on the top of her right wrist. Resident #1 was sleeping on her right side at approximately 5:30 a.m. on 08/05/24. She said she was not aware of any signs of pain or agitation during the night. She said a hospice aide brought Resident #1 to the nurses' stations on 08/05/24 at approximately 6:00 a.m. and reported the knot on her right forehead, swelling around her right eye, the bruise on the top of her right hand, and the two scratches on the top of her right wrist. She said LVN D assessed Resident #1. She said CNA E indicated she had not seen anything when she provided care prior to the hospice aide.</p> <p>During an interview on 08/06/24 at 1:16 p.m., the DON said DR/OT B indicated she (DR/OT B) reported to her (the DON) and LVN A of Resident #1 biting her right hand on 08/02/24 but she (the DON) did not recall being informed. She said LVN A should have documented in Resident #1's EHR on 08/02/24 after she was informed by DR/OT B of Resident #1 biting her hand and possible need for pain medication. She said she recalled Resident #1 had the right side of her face pressed on the dining table during the breakfast meal on 08/05/24 and that behavior may account for the swelling. She said she re-assessed Resident #1 on 08/06/24 and could not find a bruise. She said the hospital records dated 08/05/24 showed no bruise or fractures, only forehead and periorbital soft tissue swelling. She said it was her expectation staff would timely and accurately document in the residents' EHR as required. She said the negative outcome of not accurately and timely documentation could place resident at risk of not receiving care as required.</p> <p>During an interview on 08/06/24 at 1:20 p.m., DR/OT B said she was cleaning Resident #1's left hand on 08/02/24 to put a clean handroll in her palm. She said as she finished, she noticed Resident #1 was biting the top of her right hand. She said she moved Resident #1's hand away from her mouth and directed Resident #1 to not bite her hand. She said she pushed Resident #1's in her wheelchair past the DON's office and informed the DON of Resident #1 biting the top of her right hand. She said she brought Resident #1 to the nurses' station and reported the incident of Resident #1 biting her right hand to LVN A. She said she told LVN A Resident #1 might need something for pain due to her cleaning Resident #1's left hand and placing the roll in the left hand for contracture.</p> <p>During an interview on 08/06/24 at 1:43 p.m. LVN A said OT/DR B brought Resident #1 back from therapy on 08/02/24 and indicated Resident #1 appeared to be in pain due to biting the top of her (Resident #1) hand. She said she was busy with another resident and would assess Resident #1 when she finished with the other resident. She said she assessed Resident #1 and there was no signs of pain. She said she did not administer any pain medication because Resident #1 did not exhibit any signs of pain. She said she thought she documented a nurse note on 08/02/24 regarding Resident #1 biting her hand, her pain assessment, and the call to hospice. She said she did not notice Resident #1 had any swelling on her forehead, right eye area, bruise on her hand or scratches on her wrist. She said she was supposed to document in resident EHR all concerns, behaviors, assessments and results of assessments.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/09/24 at 2:58 p.m., hospice CNA H said she noticed Resident #1 had some swelling of her right forehead and eye area on 08/05/24 at approximately 5:30 a.m. She said she completed Resident #1's care and transferred her to her wheelchair. She said she noticed the swelling and knot on Resident #1's forehead was more noticeable after she was sitting in her wheelchair. She said she immediately brought Resident #1 to the nurses' station for evaluation. She said Resident #1 did not exhibit any signs or symptoms of pain. She said Resident #1 was not aggressive during her care. She said Resident #1 preferred to lay on her right side. She said she had provided Resident #1's care through hospice services for approximately 6 months and there were no previous incidents of facial swelling or knots on her forehead. She said she was not able to figure out the cause of Resident #1's facial swelling or the bruise and scratches on her right hand and wrist area.</p> <p>Record review of the facility policy Documentation in Medical Record dated 10/24/22 indicated 1. Licensed staff and IDT members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of the service, but no later than the shift in which the assessment, observation, or care service occurred.</p>		