STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455757	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spindletop Hill Nursing & Rehab Center	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interviews and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 8 (Resident #1) residents reviewed for grievances. The facility did not thoroughly investigate or take prompt action to resolve grievances voiced by Resident #1's family member on behalf of Resident #1 in August 2024. This failure could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Record review of Resident #1's face sheet indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included cerebral infarction (stroke), muscle wasting and atrophy (wasting or thinning of muscle mass), need for assistance for personal care, hemiplegia (paralysis) and hemiparesis (one-sided muscle weakness) affecting right dominant side, seizures, end stage renal disease, heart failure, and malignant neoplasm of the cardia (stomach cancer). Record review of Resident #1's MDS assessment dated [DATE] indicated she was able to make herself be understood and understood others. Resident #1 had moderately impaired cognition (BIMS was 12). She was dependent (a helper completed all activities for the resident) with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury. She was always incontinent of bladder and bowel. Record review of Resident #1's care plan dated 06/26/24 indicated she was at risk of impaired skin integrity related to bladder and bowel incontinence. Interventions included provide timely incontinent care. Record review of Resident #1's care plan dated 06/24/24 indicated Resident #1 had an ADL self-care deficit related to CVA, hemiplegia of her right dominant side, impaired balance, and limited mobility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of grievances from 06/01/24 through 09/11/24 indicated one grievance dated 09/03/24 for Resident #1. The complaint indicated Family Member A was visiting with Resident #1 and had to leave at approximately 5:00 p.m. Family Member A asked the nurse to change Resident #1. When family member E arrived at approximately 6:00 p.m., Resident #1 was not changed. Family member E got another staff to change Resident #1. The investigation indicated staff were passing trays and assisting residents with dinner. Staff finished passing the meals and assisting residents with meals and then changed Resident #1. The resolution indicated the Administrator followed up with Family Member A and discussed the finding and plan moving forward. The staff would check Resident #1 before meals to see if she needed changing before the start of service. Family member A was satisfied with the plan moving forward and the resolution. Re-education was started (no date) with nursing staff that resident care was not delayed during mealtimes. Incontinent care could be performed as long as the meal tray was not in the resident's room. CNAs and nurses were expected to work as a team to ensure the residents' care needs were met. There was no grievance report for August 2024 available for review. During an interview on 09/11/24 at 9:20 a.m., the Administrator said he was not aware of any current or unaddressed grievances related to resident care or neglect. He said he was the Grievance Official. He said he and the SW were kept track of the complaints/grievances. During an interview on 09/13/24 at 10:27 a.m., Family Member A said she had made a grievance in August 2024 after Resident #1 was left lying in feces, there was feces on her call light, and had feces under her fingernails. She said the previous Administrator G, the DON and the Admissions Coordinator were present at the meeting. She said she was not advised of the findings of the grievance. She said the DON said she would take care of it. She said she made a second grievance on 09/04/24 after Resident #1 was again left in feces/diarrhea for approximately an hour on 09/03/24 from 5:00 p.m. until 6:00 p.m. During an interview on 09/13/24 at 11:37 a.m., SW I said she was not aware of any grievances related to Resident #1's care. She said previous Administrator G was the Grievance Official. She said she was assisting the current interim Administrator/Grievance Official with grievances. During an interview on 09/13/24 at 11:42 a.m., AC H said she was present in a meeting in August 2024 (she could not recall the date) with Family Member A, the previous Administrator G, and the DON. She said Family Member A made a complaint of Resident #1 not receiving timely incontinent care and being left in feces and urine for an extended period. She said the DON said she (the DON) would take care of it. During an interview on 09/13/24 at 11:52 a.m. the DON said she did not recall a grievance meeting or Family Member A making a complaint of Resident #1's care. She said the previous Administrator G was the Grievance Official and would have written up the grievance and given the grievance for her to complete. She said she did not recall she said she would take care of it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Resident and Family Grievances policy dated 08/12/22 indicated It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal. Definitions: Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. 10. Procedure: . b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further potential violations of any resident right. c. Forward the grievance form to the Grievance Official as soon as practicable. d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: i. The date the grievance was received. ii. The steps taken to investigate the grievance. Iii. A summary of the pertinent findings or conclusions regarding the resident's concern(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decision was issued.12. The facility will make prompt efforts to resolve grievances.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 8 residents (Resident #1) reviewed for ADLS. The facility failed to provide incontinent care to Resident #1 an in a timely manner on 09/03/24. This failure could place residents who required assistance from staff for ADLS at risk of not receiving care and services to meet their needs which could result in feelings of poor self-esteem, lack of dignity, and poor health. Findings included: Record review of Resident #1's face sheet indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included cerebral infarction (stroke), muscle wasting and atrophy (wasting or thinning of muscle mass), need for assistance for personal care, hemiplegia (paralysis) and hemiparesis (one-sided muscle weakness) affecting right dominant side, seizures, end stage renal disease, heart failure, and malignant neoplasm of the cardia (stomach cancer). Record review of Resident #1's MDS assessment dated [DATE] indicated she was able to make herself be understood and understood others. Resident #1 had moderately impaired cognition (BIMS was 12)She was dependent (a helper completed all activities for the resident) with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury. She was always incontinent of bladder and bowel. Record review of Resident #1's care plan dated 06/26/24 indicated she was at risk of impaired skin integrity related to bladder and bowel incontinence. Interventions included provide timely incontinent care. Record review of Resident #1's care plan dated 06/24/24 indicated Resident #1 had an ADL self-care deficit related to CVA, hemiplegia of her right dominant side, impaired balance, and limited mobility. During an interview on 09/11/24 at 12:45 p.m., the DON said Resident #1 should not have been left in feces/diarrhea for approximately 1 hour on 09/03/24. She said she completed Resident #1's skin assessment on 09/04/24 and there were no wounds. The DON said it was her expectation the nurses would complete care if the CNAs were busy. She said residents were supposed to be checked and changed every two hours and as needed. She said residents could suffer skin breakdown and wounds if care was not provided timely. During an observation on 09/13/24 at 10:27 a.m. of an undated picture submitted to the State Surveyor by Family Member A, Resident #1 was lying in her bed at the facility with feces/diarrhea visible seeping through the center material of the diaper, seeping out of both right and left leg opening of the diaper, and fully saturated through the back of the diaper and on to the bed pad, sheets, and pillowcase. Resident #1's right hand and g-tube were lying against the feces/diarrhea. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/13/24 at 10:27 a.m., Family Member A said she was visiting Resident #1 on 09/03/24 and had to leave for work at 5:00 p.m. She said she informed LVN D (who was at the nursing station and worked the day shift) that Resident #1 had diarrhea and needed incontinent care and new sheets. She said LVN D said she would find an aide. She said Family Member E arrived to visit Resident #1 at 6:00 p.m. and found Resident #1 still lying in feces/diarrhea and dirty sheets. She said Family Member E sent her a picture of Resident #1 laying in feces/diarrhea. She said it was not acceptable Resident #1 had to lay in feces/diarrhea for an hour. She said Resident #1 was at risk for skin break down and wounds. During an interview on 09/13/24 at 12:27 p.m., CNA B said Resident #1 was clean and dry when she completed her rounds on 09/03/24 prior to serving the supper/dinner trays and feeding residents. She said she had finished feeding the residents and LVN C said she had completed incontinent care for Resident #1. She said residents were supposed to be checked and changed every two hours and as needed. CNA B said residents could suffer skin breakdown and wounds if care was not provided timely. During an interview on 09/13/24 at 12:52 p.m., LVN C said she came on her shift for 6:00 p.m. on 09/03/24. She said Resident #1's Family Member E indicated Resident #1 required incontinent care and clean sheets. She said CNA B was feeding other residents. She said she (LVN C) gathered the supplies she required and completed Resident #1's incontinent care and changed her sheets. She said residents were supposed to be checked and changed every two hours and as needed. She said residents could suffer skin breakdown and wounds if care was not provided timely. During an interview on 09/13/24 at 1:31 p.m., LVN D said she did not recall Resident #1's Family Member A requesting care or a change of sheets for Resident #1. She said she did not recall saying she would find an aide to complete incontinent care and change Resident #1's sheets. She said she completed her shift and left at 6:00 p.m. on 09/03/24. She said residents were supposed to be checked and changed every two hours and as needed. She said residents could suffer skin breakdown and wounds if care was not provided timely. Record review of the facility's Perineal Care policy dated 01/24/22 indicated It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown.