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	07/30/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 7 residents (Resident #1) reviewed for medication errors. On 07/24/25 LVN A administered 8 units of insulin outside of parameters (hold for BG less than 100). LVN B noted a change of condition for Resident #1 on 07/24/25. She was unable to rouse, clammy, and lethargic and only responded to painful stimuli. Resident #1 was admitted to hospital for hypoglycemia. The facility did not identify this significant medication error. An IJ was identified on 07/29/25. The IJ template was provided to the facility on [DATE] at 1:18 p.m. While the IJ was removed on 07/30/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems. These failures could place residents at risk of not receiving the intended therapeutic benefit of the medications, worsening or exacerbation of chronic medical conditions, hospitalization, and death.Findings included: Record review of Resident #1's face sheet dated 07/30/25 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included cerebral infarction (stroke) and Type II diabetes (the body becomes resistant to insulin or when the pancreas fails to produce insulin). Record review of Resident #1's quarterly MDS dated [DATE] indicated she was rarely able to make herself understood, sometimes understood others, and had severe impaired cognitive skills for daily decision making. Resident #1 received insulin injection for 6 of 7 days. Record review of Resident #1's care plan dated 02/17/25 (revised 07/29/25) indicated Resident #1 had diabetes. On 07/24/25 Resident #1 responded to painful stimuli only, blood sugar was 46 and she was sent to ER and admitted . Interventions dated 02/17/25 included check glucose before meals and call if above 350 and diabetes medications as ordered by physician. Monitor/document for side effects and effectiveness. Monitor/document/report PRN any ss/sx of hypoglycemia. Record review of Resident #1's physician orders dated 06/24/25 indicated Insulin Aspart Injection Solution (fast acting insulin) 100 unit/ml inject 8 units subcutaneously with meals for DM2. Hold for BG <100. Record review of Resident #1's MAR dated 07/24/25 at 5:00 p.m. indicated LVN A administered 8 units of Insulin Aspart Injection Solution. The MAR indicated hold for BG less than 100. LVN A noted Resident #1's BG was 99. Record review of Resident #1's progress nurse note dated 07/24/25 at 7:37 p.m., completed by LVN B indicated Resident #1 responded to painful stimuli only, blood sugar 46 and has worsened. Physician and RP notified. Record review of Change of Condition Form dated 07/25/25 at 12:00 a.m., completed by LVN B indicated LVN B noticed Resident #1 appeared sleeping during medication pass. Resident #1 was unable to maintain proper body posture. Blood sugar was 46. Administered Baqsimi (dry nasal spray used to treat severe hypoglycemia). in left nostril and called emergency services. Physician and RP notified. Resident #1 was transferred to hospital. Record review of Resident #1's progress nurse note dated 07/25/25 at 9:15 a.m., completed by LVN H, indicated Resident #1 was admitted to the hospital and her admitting diagnosis was hypoglycemia (low blood sugar-level). Record review of Resident #1's hospital records dated 07/25/25 indicated Resident #1 presented to the emergency department via EMS with complaints of hypoglycemia. Staff reported Resident #1 had a glucose of 99 and facility administered 8 units of insulin causing Resident #1 glucose to drop to 25. EMS administered 250 ml of D10 (dextrose/sugar), raised glucose to 169. Resident remained responsive to painful stimuli only. Record review of Resident #1's hospital records dated 07/26/25 Blood glucose earlier this a.m. was 58. Continue to monitor glucose and hold diabetic medications and insulin. Record review of Resident #1's hospital records dated 07/27/25 indicated hypoglycemia was resolved. Discharge plan for tomorrow. Record review of Resident #1's progress nurse noted dated 07/28/25 at 5:37 p.m., completed by LVN J indicated Resident #1 was readmitted to the facility in stable condition. During an interview on 07/29/25 at 10:50 a.m., the DON said she was not aware LVN A administrated Resident #1's insulin outside of parameters on 07/24/25. She said she was aware the physician was notified of Resident #1's change of condition and transport to hospital for evaluation and treatment. She said she reviewed Resident #1's clinical record for a change of condition but did not investigate the possible reasons for hypoglycemia. She said it was her expectation LVN A would have held Resident #1's insulin on 07/24/25 due to the BG being out of parameters. She said the risk for Resident #1 receiving insulin out of parameters were hypoglycemia leading to coma and possible death. During an interview on 07/29/25 at 11:18 p.m., LVN A said she must have made a mistake on 07/24/25 when she administered Resident #1's insulin outside of parameters. She said she did

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 8 residents (Resident #1) reviewed for resident records. The facility failed to ensure Resident #2's BG parameters were updated accurately on the electronic physician orders and MAR as of 07/02/25. This failure could place residents at risk for delayed care and appropriate interventions. Findings included: Record review of Resident #2's face sheet dated 07/29/25 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included Type II diabetes and dementia. Record review of Resident #2's annual MDS dated [DATE] indicated she was usually able to make herself understood and understood others. She had severe cognitive impairment (BIMS-3). Record review of Resident #2's care plan dated 11/20/20 indicated she had Type II diabetes. Interventions included diabetes medications as ordered by a doctor. Monitor/document for side effects and effectiveness. Record review of Resident #2's physician orders dated 07/02/25 indicated -Novolog Injection Solution 100 UNIT/ML Inject 6 unit subcutaneously with meals. Hold if BS is less than 200. Record review of Resident #2's physician orders dated 07/29/25 indicated -Novolog Injection Solution 100 UNIT/ML Inject 6 unit subcutaneously with meals. Hold if BS is less than 200. Record review of Resident #2's MAR dated 07/02/25 through 07/29/25 indicatedNovolog Injection Solution 100 UNIT/ML Inject 6 unit subcutaneously with meals. Hold if BS is less than 200.The insulin was held if BG was less than 100. Record review of Resident #2's MAR dated 07/29/25 from 5:00 p.m. through 07/30/25 indicated Novolog Injection Solution 100 UNIT/ML Inject 6 unit subcutaneously with meals. Hold if BS is less than 100.The insulin was held if BG was less than 100. Record review of Resident #2's nurse progress note dated 07/02/25 at 9:32 a.m., completed by LVN H indicated new orders from NP D Novolog 6 units with meals. Hold if BG less than 100. During an interview on 07/30/25 at 9:00 a.m. the DON said LVN H made a typo error in the Resident #2's electronic record when she was updating the physician orders and it was not noticed. She said NP D was notified on 07/29/25 and she was waiting for confirmation for the new order to hold Resident #2's insulin if her NG was less than 100. During an interview on 07/30/25 at 9:33 a.m., NP D she reviewed Resident #2's physician orders and MARs on 07/02/25. She said it was a typo error for Resident #2's Novolog to be held for BS less than 200. She said insulin was generally held if BG was lower than 100. She said she reviewed Resident #2's BG parameters for the previous months and said it should have been 100 and not 200. She said she ordered it changed to hold insulin if BG was less than 100 on 07/02/25. She said there was no negative outcome. During an interview on 07/30/25 at 1:52 p.m., LVN H said she put the new orders from NP H on 07/02/25 in the electronic for Resident #2's Novolog Injection Solution 100 UNIT/ML Inject 6 unit subcutaneously with meals. Hold if BS is less than 200. She said it was an error at 200 that was supposed to be corrected to read 100. She said it was generally good nursing judgment to hold insulin if BG was less than 100. She said she did not notice the hold if less than 200 on the orders or the MAR when she checked Resident #2's BG or when she administered the insulin. She said she always held the insulin if the BG was less than 100. Record review of the facility's policy Documentation in Medical Record dated 10/24/22 indicated Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.