

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 08/05/2026
NAME OF PROVIDER OR SUPPLIER Spindletop Hill Nursing and Rehabilitation 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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the medication error rate was not five percent (5%) or greater. The facility had a medication error rate of 26.67%, based on 8 errors out of 31 opportunities, which involved 3 of 5 residents (Resident #41 Resident #48, Resident #6) and 3 of 4 staff (MA I, MA F, LVN N) observed during medication administration reviewed for pharmacy services.1.The facility failed to ensure MA I administered Resident #41's ordered dose of ferrous sulfate 326 mg. She administered ferrous sulfate 325 mg oral tablet. 2.The facility failed to ensure MA F administered Resident #48's ordered dose of ferrous sulfate 324 mg oral tablet. She administered ferrous sulfate 325 mg oral tablet. 3.The facility failed to ensure MA F administered Resident #48's ordered dose of magnesium oxide oral tablet 250 mg. She administered magnesium oxide 240 mg oral tablet. 4.The facility failed to ensure MA F administered Resident #48's ordered dose of vitamin c 1000mg oral tablet, instead, she administered one vitamin c 500mg tablet. 5.The facility failed to ensure MA F administered Resident #48's ordered dose of folic acid oral tablet 1 mg instead she administered folic acid 400 mcg oral. 6.The facility failed to ensure MA F administered Resident #48's ordered dose of methocarbamol oral tablet 1000 mg instead she administered one methocarbamol 500 mg oral tablet. 7.The facility failed to ensure LVN N administered Resident #6's ordered dose of miralax oral powder 17 gm/scoop (polyethylene glycol 3350), and instead, administered another resident's MiraLAX oral powder 17 gm/scoop (polyethylene glycol 3350) through her g-tube. 8. The facility failed to ensure LVN N administered Resident #6's ordered water flush at the start and end of the medication administration. These failures could place residents at risk for receiving inaccurate medication dosage leading to an altered therapeutic response. Findings included: 1.Record review of Resident #41's Face Sheet, dated 08/05/2026, indicated a [AGE] year-old female who re-admitted to the facility on [DATE] with diagnoses of cerebral infarction (stroke), muscle wasting, constipation, hypertension (high blood pressure), mixed hyperlipidemia (high cholesterol). Record review of Resident #41's Quarterly MDS assessment, dated 02/22/2026 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15, indicating she had severely impaired cognition. Record review of Resident #41's undated Care Plan, indicated interventions give medications as ordered by the physician. Record review of Resident #41's medication administration record (mar) indicated ferrous sulfate oral tablet (ferrous sulfate) give 326 mg by mouth one time a day. An observation on 08/03/2026 at 9:46 a.m. indicated MA I performed hand hygiene, prepared and administered iron 325mg (ferrous sulfate)- 1 tablet to Resident #41. During an interview on 08/03/2026 at 10:22 a.m., with MA I, she said when a medication did not match the order, she was trained to inform her charge nurse and follow the instructions she gave. She said she did not notice the mg did not match because she was nervous. She said she is responsible for ensuring the dosage is correct before administering it to residents. 2.- 6. Record review of Resident #48's Face Sheet, (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 08/05/2026, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of osteomyelitis (an infection in a bone), muscle wasting, anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues.) Record review of Resident #48's Quarterly MDS, dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she was cognitively intact. Record review of Resident #48's order summary dated 08/05/2026 indicated the following orders:ferrous gluconate oral tablet 324 (37.5 fe) mg (ferrous gluconate)magnesium oxide oral tablet 250 mg (magnesium oxide)vitamin c oral tablet (ascorbic acid) give 1000 mgfolic acid oral tablet (folic acid) give 1000 mcgmethocarbamol oral tablet 1000 mg During an observation on 08/04/2026 at 10:45 a.m. indicated MA F performed hand hygiene, prepared and administered the following medications to Resident #48. ferrous gluconate oral tablet 325 mg (ferrous gluconate)- 1 tabletmagnesium oxide oral tablet 240 mg (magnesium oxide)- 1 tablet vitamin c oral tablet (ascorbic acid) give 1000 mg- 1 (500 mg) tabletfolic acid oral tablet (folic acid) give 1000 mcg- 1 (400mcg) tabletmethocarbamol oral tablet 1000 mg- 1 (500 mg) tablet During an interview on 08/05/2026 at 10:42 a.m., with MA F she said she did not notice the mg did not match for the folic acid. She said she had been trained on medication administration. She said she was responsible for ensuring the dosage was correct before administering it to residents. She said the potential risk to the residents was receiving the wrong dosage of medication and causing harm. 7. - 8. Record review of Resident #6's Face Sheet, dated 08/05/2026, indicated a [AGE] year-old female who admitted to the facility on with diagnoses of cerebral infarction (stroke), dysphasia (a condition that affects the ability to produce and understand spoken language), abdominal pain (stomach pain). Record review of Resident #6's Quarterly MDS, dated [DATE] indicated the Brief Interview for Mental Status (BIMS) was unable to be completed due to her impaired cognition. Record review of Resident #6's undated care plan indicated Give medications as ordered. Monitor for side effects, effectiveness. Record review of Resident #6's order summary dated 08/05/2026 indicated the following orders:-miralax oral powder 17 GM/scoop (polyethylene glycol 3350) (give 1 scoop via g-tube) -npo diet npo texture, npo (nothing by mouth) consistencyenteral feed order every shift flush feeding tube with 50 ccs of water before and after medication administration. During an observation on 08/05/2026 at 8:50 a.m. indicated LVN N performed hand hygiene and prepared miralax oral powder 17 GM/scoop (polyethylene glycol 3350) (give 1 scoop via g-tube) for Resident #6. by mixing 1 scoop with 15ml of water. LVN N used another resident's bottle of MiraLAX. Resident #6 did not have her own bottle of MiraLAX oral powder on the medication cart. During the observation, LVN N performed hand hygiene, applied PPE, and entered Resident #6's room. LVN N disconnected Resident #6's tube feeding, checked residual with g-tube syringe (5 ml residual noted). She began medication administration without flushing g-tube with 50 ccs of water as stated in order. During an interview on 08/05/2026 at 11:00 a.m., with LVN N, she said she had not flushed Resident #6's g-tube before administering her medications because she was nervous, she said she usually did. She said she did not notice the names did not match on the miralax bottle. She said she was nervous and overlooked it. She said the potential risk to the resident was her getting the wrong medication and potentially causing harm. During an interview on 08/05/2026 at 3:00 p.m., with the DON, she said it was her expectation for staff, that administer medications, to follow facility's policy and correctly administer medications safely. She said that had not administered medications correctly would be re-trained on medication administration. The DON said the potential risk to the residents was not receiving the correct medication or dosage. She said staff (MA's and Nurses had been re-trained and in-serviced on medication administration since the last survey. During an interview on 08/05/2026 at 3:10 p.m., with the Administrator, he said his expectation was for staff to follow the facility's medication policy and to ask questions for clarification.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 2 of 6 residents (Residents #4 and #76) observed for infection control.1. The facility failed to ensure the Wound Care Nurse performed hand hygiene between glove changes when she provided wound care to Resident #4.2. The facility failed to implement EBP for Resident #76 during incontinent care on 08/04/2026. This failure could place residents and staff at risk for cross-contamination and development of infections.Findings included: 1. Record review of Resident #4's admission record dated 08/05/2026 indicated she was a [AGE] year-old-female admitted [DATE] and readmitted [DATE] with diagnoses of diabetes mellitus (a chronic condition where blood sugar levels stay too high), end stage renal disease (kidney s can no longer clean blood or remove extra fluid and patients need dialysis to survive), dependence on renal dialysis (a person's kidneys have failed and they rely on a machine to filter waste and extra fluid from their blood to stay alive), and cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off). Record review of Resident #4's quarterly MDS assessment, dated 05/04/2026, indicated a BIMS score of 9, indicated moderately impaired cognition, diagnoses of end stage renal disease, diabetes mellitus, and dependence on renal dialysis. The assessment indicated a risk of pressure ulcers, pressure reducing device for bed, and application of nonsurgical dressings. Record review of Resident #4's care plan, with a target date of 10/05/2026 indicated Resident #4 had alteration in skin integrity, a sacral abscess to sacrum, history of refusing wound care and had interventions included apply treatment as orders and follow enhanced barrier precautions. Record review of physician's orders for Resident #4, dated 08/03/2026, indicated cleanse abscess to sacrum with wound cleanser, pat dry, apply betadine, cover with gauge island 3 times weekly and as needed with a start date of 07/28/2026 and enhanced barrier precautions with a start dated of 01/21/2026. During an interview on 08/03/2026 at 10:50 a.m., Resident #4 was sitting up in a wheelchair she said she had sore on her bottom that was being treated by staff. She said they were doing a good job treating her. During an observation and interview on 08/05/2026 at 9:40 a.m., the Wound Care Nurse cleaned a bedside table, applied wax paper and set up her supplies. She entered the room with her supplies, closed the door then washed her hands applied a gown and applied gloves. Resident #4's soiled dressing had been removed previously. The Wound Care Nurse cleaned the wound and removed her gloves but did not perform hand hygiene and applied new gloves. She patted the wound dry with gauze and removed gloves but did not perform hand hygiene and applied new gloves. She performed wound care and applied the new dressing and removed her gloves but did not perform hand hygiene and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	applied new gloves. The Wound Care Nurse pulled Resident #4's pants up and adjusted her in bed. She removed her trash and disposed of it. After leaving the resident's room the Wound Care Nurse said she should have cleaned her hands between glove changes and did not. She said she got nervous. The Wound Care Nurse said she was educated on proper wound care and was aware she should have cleaned her hands after removing her gloves and before applying new gloves. She said the resident risk of not cleaning her hands between glove changes was a potential spread of infection. 2. Record review of Resident # 76's admission record dated 08/03/2026 indicated she was a [AGE] year old female, initially admitted on [DATE] and readmitted on [DATE], with diagnoses including cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), dysphagia (difficulty swallowing), and gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food) tube status. Record review of Resident #76's quarterly MDS assessment, dated 07/09/2026, indicated she was severely impaired cognitively. She rarely/never made herself understood and rarely/never understood others. She was dependent on facility staff and/or maximum assistance for self-care and mobility tasks. Record review of Resident #76's care plan, revised 08/16/2024 indicated Resident #76 had the need for Enhanced Barrier Precautions due to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food) tube with interventions place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high- contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Record review of physician's orders for Resident #76, dated 08/19/2024, indicated EBP Enhanced Barrier Precautions: Use gown and gloves for high contact resident care activities for those with known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDR. (residents with wounds or indwelling medical devices) every shift. During an observation on 08/04/2026 at 2:30 p.m., outside of Resident #76's room there was an EBP signage. There was an over-door organizer on Resident #76's door with PPE (gloves, gowns, goggles,) available. Resident #76 was lying in bed; she did not respond appropriately to interview questions. During an observation on 08/04/2026 at 2:58 p.m., CNA C and CNA D provided perineal/incontinent (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care to Resident #76. CNA C and CNA D, during direct contact with Resident #76, did not wear gowns while providing perineal/incontinent care. During an interview on 08/04/2026 at 3:15 p.m., CNA C and CNA D said they failed to follow the EBP because they forgot to wear a gown during Resident #76's perineal/incontinent care. Both said they were trained in EBP and should have applied gowns prior to entering the room to perform care. They said Resident #76 was on EBP because she had a gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food) tube. They said that not wearing a gown during the perineal/incontinent care could spread infection or cause cross contamination. During an interview on 08/04/2026 at 3:45 p.m., the ICP said she expected the facility staff and vendors to follow the EBP policy when providing direct care to residents identified as requiring EBP which included residents with chronic wounds, indwelling devices, and MDROs. She said Resident #76 was on EBP because she had a gastronomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food) tube for her continuous feedings requiring precautions and staff and vendors should be wearing PPE when providing direct care/incontinent care. The ICP said she provided facility staff training on infection control measures and EBP routinely, at a minimum of quarterly, and as needed. The ICP said not following the EBP as ordered could lead to spread of infection, transfer of bacteria, putting both staff and residents at risk. She said all staff should follow all infection control procedures. During an interview on 08/05/2026 at 3:50 p.m., the DON said she expected facility staff to apply PPE when providing direct resident care for residents with EBP ordered. She said Resident #76 was on EBP because she had a gastrostomy tube (indwelling medical devices - an opening into the stomach from the abdominal wall, made surgically for the introduction of food) requiring precautions and staff should be wearing the proper PPE while providing direct care to her. She said EBP should be followed by staff and vendors with direct care provided to residents with MDROs, wounds, and indwelling devices. The DON said the risk of failing to perform EBP could lead to spread of MDROs, infections to other residents or even staff. The DON said the Wound Care Nurse was responsible for wound care in the facility when she was there and was educated on proper completion of wound care. She said the Wound Care Nurse should have washed her hands or used ABH gel after changing her gloves each time. She was overwhelmed. She said the potential resident risk of not performing hand hygiene between glove changes was a potential for infection. The DON said her expectation was all nurses follow all infection control policies. During an interview on 08/05/2026 at 4:15 p.m., the Administrator said his expectations were that all staff adhere to the EBP policy, orders and signage when providing high- contact care for residents requiring EBP (residents with MDROs, chronic and pressure wounds, and indwelling devices). He said not following EBP as required could cause spread of infection or cross contamination. The Administrator said the Wound Care Nurse was educated on proper wound care and responsible for completing wound care on the residents in the facility. He said she was nervous. The Administrator (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the resident risk of not cleaning her hands between glove changes was potential for infection. He said his expectation was all staff follow infection control policy and procedures. Record review of a facility policy titled, Hand Hygiene, dated 10/24/2022, indicated, .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, resident, and visitors. Hand Hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic had rub, also known as alcohol-based hand rub (ABHR). a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of facility policy titled, Enhanced Barrier Precautions, dated 12/30/2025, indicated the following: . 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 i. Wounds (e.g., chronic wounds such as pressure ulcers diabetic foot ulcers unhealed surgical wounds and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO . 3. Implementation of enhanced barrier precautions: a. Make gowns and gloves available immediately here or outside of the residence room. Note: face protection may also be needed if performing activities with risk of splashes or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the residence room. 4. High contact resident care activities include.d. Providing hygiene.f. changing briefs or assisting with toileting .		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than two hours after the allegations were made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for one of four (Resident #80) residents reviewed for abuse and neglect. The facility failed to report an allegation of abuse within 2 hours to HHSC of learning about alleged abuse that involved Resident #80 allegedly during the week of July 27th, 2026. This failure could place residents at risk of not receiving timely investigation into allegations of abuse and neglect, continued abuse, fear, and retaliation. The findings included: Record review of Resident #80's face sheet dated 08/03/2026 indicated a [AGE] year-old female was admitted to the facility on [DATE]. Resident #80 had diagnoses of cerebral infraction (stroke), lack of coordination, and anxiety disorder. Record review of Resident #80's Quarterly MDS assessment dated [DATE] indicated she made herself understood and others could understand her. She had a BIMS score of 15/15 indicating she was cognitively intact. Record review of Resident 80's undated care plan indicated the resident has a behavior problem with an intervention of intervene as necessary to protect the rights and safety of others. Approach/ speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Record review of the TULIP case detailed an allegation involving Resident #80 was learned about on 08/03/2026 at 1:00 p.m., indicated it was not reported to HHSC until 08/03/2026 at 5:04 p.m. Record review of CNA P's timesheet indicated she was had not worked since 08/02/2026. Record review of the Provider Investigation Report dated 08/03/2026 indicated Resident #80 allegedly felt bullied by CNA P sometime last week, she could not recall. She alleged it occurred around 6:30 p.m., (smoke break). An observation and interview on 08/03/2026 at 12:00 p.m., indicated Resident #80 was lying in bed watching tv. There were no bruises, markings noted on Resident #80. She said the way CNA P had talked to her made her feel like she was bullied. Resident #80 said she could not recall what CNA P had said to her nor the setting they were in when it happened. She was said she had recalled the alleged incident happened on 08/02/2026. She said she had not told anyone because she was waiting to get out of bed. During an interview on 08/03/2026 at 1:00 p.m., the Administrator indicated he initiated his investigation of the allegation at 1:00 p.m. He said he should have reported the allegation within 2 hours. The Administrator said he re-read the provider letter on reporting abuse and read that alleged abuse was to be reported within two hours. He said he was responsible for reporting to HHSC within 2 hours. He said CNA P was suspended until the investigation was complete. He said CNA P did not have a history of abuse allegations. During an interview on 08/05/2026 at 3:00 p.m., with CNA P, she said she had never been Resident #80's assigned CNA. She said she was the assigned staff member that took the smokers outside to smoke. She said after the smoke break was over Resident #80 could not push her wheelchair inside by herself, so she helped push her wheelchair. She said Resident #80 accused her of trying to push her out of her wheelchair. She said she told the resident that she was trying to help her wheelchair over the hump. Record review of facility's policy titled Abuse, Neglect, and Exploitation dated: 07/11/2025. Policy: It is the policy of this facility to provide (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: A. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the status of the residents for 2 of 18 (Resident #2 and Resident #48) residents reviewed for accuracy of assessment. 1. The facility failed to accurately complete the MDS assessment to indicate Resident #2's PASRR status was positive. 2. The facility failed to accurately complete the MDS assessment to indicated Resident #48 did not receive insulin injections. These failures could place residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: 1. Record review of Resident #2's admission record indicated a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnosis of major depressive order (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), stoke, hemiplegia (paralysis) and hemiparesis (weakness) following a stroke, and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #2's annual MDS assessment, dated 03/13/2026, indicated a BIMS score of 10 indicating Resident #2 was moderately impaired cognitively. The MDS Section A1500: Preadmission Screening and Resident Review (PASRR) Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDS was coded 0 indicating No conditions related to ID/DD Status. Record review of Residents #2's care plan updated on 07/08/2026 indicated she received antipsychotic medications for major depressive disorder with monitoring and reporting interventions. No care plan identified for Resident #2 having PASRR positive status for mental illness and interventions in place. Record review of Resident's #2's PASRR Level 1 Screening dated 07/24/2025 indicated Resident #2 was PASRR positive for a mental illness. Record review of Resident's #2's PASRR Comprehensive Service Plan form dated 08/27/2025 indicated Resident #2 was PASRR positive for MI and received MI specialized services. Record review of Resident's #2's PASRR Quarterly Comprehensive Service Plan form dated 04/15/2026 indicated Resident #2 continued to be PASRR positive for MI and continues to receive MI specialized services. During an interview on 08/05/2026 at 11:00 am, Resident #2 and Resident #2's family members said Resident #2 was PASRR positive since facility admission, attended quarterly PASRR meetings, and she receives MI specialized services. 2. Record review of Resident #48's admission record dated 06/20/2026 revealed a [AGE] year-old (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Osteomyelitis (bone infection), hypertension (when your blood pressure is consistently too high over time), and GERD (when stomach acid flows back up into the esophagus). The admission record did not reveal a diagnosis of diabetes disorder. Record review of Resident #48's MDS assessment completed on 06/23/2026 indicated the resident received insulin injections. Record review of Resident #48's care plan completed on 06/20/2026 indicated no mention of diabetes disorder or that the resident received insulin. Record review of Resident #48's MAR dated June 2026 indicated no insulin orders. Record review of Resident #48's Physician orders dated July 2026 indicated no insulin orders. During an Interview on 08/04/2026 at 1:45 p.m., Resident #48 stated she has no history of diabetes, nor has she ever taken insulin before. Resident #48 said she only had blood thinner injections in her stomach while in the facility. During an Interview on 08/05/2026 at 11:53 a.m., the MDS Coordinator A (skilled services) said Resident #48's MDS assessment, completed on 06/23/2026, should not have insulin marked under the injections section and it was a data entry error. She said she should have put a zero in the insulin injection section. She said the only injections Resident #45 received were anticoagulant injections. She said Resident #2 was PASRR positive, receiving PASRR services, and the annual MDS assessment for 03/13/2026 was incorrect. She said she completed skilled care MDS's, and completed Resident #2's annual MDS dated [DATE] because she was receiving skilled care at the time. She said the Regional MDS Coordinator reviewed the MDS for accuracy and completion. She said she had been doing MDS assessments for over 30 years and received MDS training quarterly from corporate staff. She said inaccurate assessments had low risk of harm, and could lead to residents not receiving needed services. She said she followed the most recent RAI Manual for guidance for completing the MDSs. She said she would modify Resident #45 and #2 incorrect MDS's to reflect the correct information. During an interview on 08/05/2026 at 12:05 p.m., the MDS Coordinator B (long-term care) said she was responsible for completion of the long-term care residents' MDSs, and Resident #2 was a long-term care resident and received PASRR services, and she should have communicated that Resident #2 was PASRR positive to MDS Coordinator A to accurately complete the annual MDS, dated [DATE]. She said the Regional MDS Coordinator reviewed all the MDSs for accuracy and completion. She said she received MDS training quarterly from the corporate MDS Coordinator staff. She said inaccurate assessments had a low risk of harm and could lead to residents not receiving needed services. She said she followed the most recent RAI Manual for guidance for completing the MDSs. During an interview on 08/05/2026 at 12:48 p.m., the DON said the MDS Coordinators were responsible for all MDS assessments in the facility with the Regional MDS Coordinator reviewing the MDS for accuracy and completion. The DON said she expected her MDS coordinators to be efficient and accurate when submitting MDS forms. The DON said the resident risk of an MDS marked incorrectly was the MDS may not reflect the accurate residents care needed. The DON said they used (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the RAI Manual for guidance for completing the MDSs. During an interview on 08/05/2026 at 2:15 p.m., the Administrator said the MDS Coordinator was responsible for all MDSs in the facility and were trained in the completion of MDSs. He said the Regional MDS Coordinator completed random MDS audits for accuracy. The Administrator said the resident risk of an MDS not marked correctly was the MDS may not be an accurate reflection of the resident and the resident's care. He said his expectation was all MDSs be correct and accurate. The Administrator said they did not have a policy regarding MDS completion, the facility utilized the RAI Manual for guidance for completing the MDSs. Record review of the facility's policy titled, Documentation, indicated the following in part. Goal: 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 dated October 2025 indicated the following: .A1500: Preadmission Screening and Resident Review (PASRR). Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. N0300: Injections Coding instructions Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by injection. Insulin injections are counted in this item as well as in Item N0350. N0350: Insulin Coding Instructions: Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received. Enter in Item N0350B, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders. SECTION I: ACTIVE DIAGNOSES Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood, or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 18 residents (Resident #2) reviewed for comprehensive resident centered care plans. The facility failed to ensure Resident #2's comprehensive care plan was reviewed and revised with having PASRR positive status for mental illness. This failure could place residents at risk of not receiving the care and services to meet their needs. Record review of Resident #2's admission record indicated a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnosis of major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), stroke, hemiplegia (paralysis) and hemiparesis (weakness) following a stroke, and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #2's annual MDS assessment, dated 03/13/2026, indicated a BIMS score of 10 indicating Resident #2 was moderately impaired cognitively. The MDS Section A1500: Preadmission Screening and Resident Review (PASRR) Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDS was coded 0 indicating No conditions related to ID/DD Status. Record review of Residents #2's care plan updated on 07/08/2026 indicated she received antipsychotic medications for major depressive disorder with monitoring and reporting interventions. No care plan identified for Resident #2 having PASRR positive status for mental illness and interventions in place. Record review of Resident's #2's PASRR Level 1 Screening dated 07/24/2025 indicated Resident #2 was PASRR positive for a mental illness. Record review of Resident's #2's PASRR Comprehensive Service Plan form dated 08/27/2025 indicated Resident #2 was PASRR positive for MI and received MI specialized services. Record review of Resident's #2's PASRR Quarterly Comprehensive Service Plan form dated 04/15/2026 indicated Resident #2 continued to be PASRR positive for MI and continues to receive MI specialized services. During an interview on 08/05/2026 at 11:00 am, Resident #2 and Resident #2's family members said Resident #2 was PASRR positive since facility admission, attended quarterly PASRR meetings and she receives MI specialized services. During an interview on 08/05/2026 at 11:53 a.m., (the skilled services) MDS Coordinator A said Resident #2 was PASRR positive and received PASRR services. She said Resident #2's care plan should indicate that she was PASRR positive and include appropriate interventions. She said Resident #2's care plan should have been revised when Resident #2 became PASRR positive or when the facility discovered the care plan was not correct. She said the annual MDS and comprehensive care plan was not accurate, and Resident #2 should have been identified as PASRR positive. She said if a care plan was not reviewed and updated with changes, it could affect resident care. During an interview on 08/05/2026 at 12:05 p.m., the long-term care MDS coordinator B said Resident #2 was PASRR positive and received PASRR services. She said Resident #2's care plan should indicate that she is PASRR positive with appropriate interventions. She said not having an accurate care plan could affect resident care needs. During an interview on 08/05/2026 at 3:50 p.m., the DON said the MDS Coordinators were responsible for the revision of the resident's care plan at the time of the assessment. The DON said the inaccurate care plans should have been identified and revised during the IDT care plan meeting. She said inaccurate care plans could result in affecting resident care needs being met. The DON said Resident #2's care plan should reflect that she (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was PASRR positive. She said the expectation was for all residents' care plans to be completed accurately. During an interview on 08/05/2026 at 4:00 p.m., the Administrator said comprehensive care plans should be reviewed and revised with significant changes, quarterly, annually, and as needed with resident care changes. He said the MDS Coordinators and IDT should be reviewing the care plan and making sure all the care need areas were addressed. He said not having an accurate care plan could affect resident care needs, and he expected each resident's comprehensive care to be reviewed, revised and accurate. Record review of the facility's policy titled, Comprehensive Care Plans dated 10/24/2022 indicated the following: . Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines:. 3.The comprehensive care plan will describe, at a minimum, the following:. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations.		

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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** Based on observations, interviews, and record reviews, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 2 of 6 (Resident #16 and Resident #17) residents reviewed for quality of life in that: 1. Resident #16 had noticeable long strands of facial hair on her chin that she wanted staff to shave for her. 2. Resident #17 had noticeable thick long strands of facial hair on her upper lip and chin that she wanted staff to shave for her. This failure could affect residents who need assistance with grooming facial hair and could result in low self-esteem and embarrassment. The Findings included: 1. Record review of Resident #16's face sheet dated August 3, 2026, indicated she was admitted on [DATE]. Resident #16 had diagnoses of multiple sclerosis (a chronic condition where the immune system mistakenly attacks the protective covering of nerve cells), lack of coordination, need for assistance with personal care, muscle wasting, epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors), and blindness right eye. Record review of Resident #16's Quarterly MDS assessment dated [DATE], indicated she made herself understood, she understood others, and had a BIMS (Brief Interview for Mental Status) score of 15/15 (cognition intact). She had severely impaired vision, required assistance from staff for personal hygiene, had right eye blindness, and required assistance with personal care. Record review of Resident #16's undated Care Plan indicated The resident has an ADL Self Care Performance Deficit related to impaired balance, limited mobility, blind, MS (multiple sclerosis) .Intervention: Personal Hygiene: the resident requires (limited assistance) by (1) staff with personal hygiene and oral care. During an observation on 08/03/2026 at 09:10 a.m., Resident #16 's face had long facial hair on chin area. During an observation on 08/04/2026 at 1:00 p.m. Resident 16's face had long facial hair on her chin area. During an observation on 08/05/2026 at 3:00 p.m. Resident 16's face had long facial hair on her chin area. During an interview on 08/03/2026 at 09:12 a.m. with Resident #16, she said she wanted the hair on her chin to be shaved. Resident #16 said she was aware of her facial hair. Resident #16 said she had depended on staff to shave her because she could not see well. She said staff used to shave her once a week regularly then had stopped. Resident #16 said she would have liked staff to have shaved her regularly to keep her chin hair from being noticeable. She said she would go to bible study on Tuesdays and Sundays, and she would have liked to be shaved so she would look presentable. 2. Record review of Resident #17's face sheet dated August 3, 2026, indicated she was re-admitted to the facility on [DATE]. Resident #17 had diagnoses of cerebral infraction (stroke), Hemiplegia (complete loss of strength or paralysis (inability to move) on one side of the body) and Hemiparesis (weakness on one side of the body), need for assistance with personal care, muscle wasting, lack of coordination, absence of the right and left leg above the knee. Record review of Resident #17's Quarterly MDS assessment dated [DATE], indicated she sometimes made herself understood, and usually understood others. She had a BIMS score of 04/15 (severely cognitively impaired). She had impaired vision, and required maximum assistance from staff with personal hygiene. Record review of Resident #17's undated Care Plan indicated The resident has an ADL Self Care Performance Deficit related to Hemiplegia, impaired balance, limited mobility, musculoskeletal (muscles, bones, joints, ligaments, tendons, and connective tissues, supporting movement, posture) impairment, stroke. Intervention: Personal Hygiene: the resident requires (maximum assistance) by (1) staff with personal hygiene and oral care. During an observation on 08/03/2026 at 09:25 a.m., Resident #17 's face had thick and long facial hair above her upper lip and chin area. During an (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 08/04/2026 at 1:10 p.m. Resident 17's face had thick and long facial hair above her upper lip and chin area. During an observation on 08/05/2026 at 3:12 p.m. Resident 17's face had thick and long facial hair above her upper lip on her chin area. During an interview on 08/03/2026 at 10:14 a.m. with Resident #17, she answered yes when asked if she wanted her facial hair shaved. She could not say the last time staff shaved her. During an interview on 08/05/2026 at 2:15 p.m. with CNA M, he said Resident #16 and Resident #17 had long facial hair. CNA M said he had not shaved Resident #16 and Resident #17 for a while. He said both Residents #16 and #17 were dependent on staff to shave their facial hair. He said residents should be shaved if they want. He said not regularly shaving the residents could potentially result in the residents developing low self- esteem. He said CNAs and nurses were responsible for ADL care. During an interview on 08/03/2026 at 3:25 p.m. with LVN L, she said Resident #16 and Resident #17 required assistance from staff to shave their facial hair. LVN L said the CNAs and nurses were responsible for providing personal hygiene, that included shaving to residents that required assistance. She said staff needed to offer residents (male or female) hair removal, if residents wanted it. LVN L said personal hygiene was important because residents had the right to have their own grooming preferences. During an interview on 08/05/2026 at 4:11 p.m. with the DON, she said Resident #16 and Resident #17 did not have a history of refusing staff to shave them. She said if the residents refused care, it should be documented. She said the potential risk to the residents was a decrease in their self-esteem. She said the CNAs and the nurses were responsible for shaving residents. She said her expectation was for staff to address any of the residents' needs and to shave them during showers. During an interview on 08/05/2026 at 4:20 p.m., with the Administrator, he said his expectation was for staff to follow the facility's policy and meet residents' needs by shaving their facial hair. He said the CNAs and the nurses were responsible for shaving residents. The Administrator said the risk to the residents not receiving appropriate ADL care was low esteem. Record review of facility's policy titled: Activities of Daily Living (ADLs), dated 05/26/2023, indicated Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 4. Documentation shall be completed at the time of service, but no later than the shift in which care service occurred.		

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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 2 of 4 medication carts (Memory Care and Station and Hall 100 medication aide medication cart) reviewed for medication storage. 1. The facility failed to ensure medication was not on the floor of the Memory Care unit in front of the memory care medication cart on 8/4/2026 at 1:25 p.m. 2. The facility failed to ensure the Hall 100 medication cart was locked without keys in the keyhole and supervised. 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 include: 1. During an observation and interview on 08/4/2026 at 1:25 p.m., LVN E in the memory care unit was observed checking meal tickets. LVN E observed a small white round pill (with a 49 impressed on one side of the pill) on the floor in front of the memory care medication cart. LVN E picked up the pill and did a search on her phone to identify the pill as an anti-itch medication. LVN E said only one resident in the memory care unit has an anti-itch medication. LVN E compared and identified the round white pill found on the floor to be an anti-itch medication of Hydroxyzine 25 mg. LVN E said she had just administered a resident an anti-itch medication prior to lunch, but she verified the medication was in the cup and that the resident swallowed the administered meds. LVN E said she was unsure where the pill on the floor came from, but she placed it in the biohazard box for destruction. Observed 12 memory care unit residents sitting in wheelchairs or chairs eating lunch. Observed 2 memory care unit residents independently ambulatory and no residents observed near the medication cart or pill found on the floor. During an interview on 08/04/2026 at 1:30 p.m., LVN E stated it was her responsibility to make sure all medications were stored and locked in the medication cart. LVN E said she was unsure where the anti-itch pill found on the floor came from, but she should make sure medications are secure and not on the floor around the medication cart prior, during and after administering medications. LVN E said if it was from the anti-itch medication she administered, she had just administered the medication prior to lunch, so it had not been unsecured for more than 15-20 minutes. LVN E said only 2 of the residents on memory care had the physical mobility and dexterity to bend down and pick up a small pill from the floor and with those 2 it would be difficult and facility staff alertness would intervene. LVN E said the negative outcome was that another resident could have picked up the medication and ingested it causing drowsiness. LVN E said she was trained in medication storage, use of medication carts, and to keep medications locked up when not in use. 2. During an observation and interview on 08/05/2026 from 9:40 a.m. to 9:43 a.m., indicated MA F's medication cart was noted to be unsecured with the keys inside of the key lock and unsupervised on Hall 100. MA F was in a resident's room when that medication cart was seen unattended. The medication cart was front facing with the drawers facing the hallway with the lock mechanism out (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(indicating it was unlocked). Inside the medication cart Drawer #1 were OTC (over the counter) aspirin, vitamins, minerals and eye drops. Drawer #2 had a locked compartment with several controlled substances, and multiple resident's individual medication bubble-blister packets. During an interview with MA F, she said she was assigned the Hall 100 medication aide medication cart, and it should had been locked. She said she should not have left the cart keys inside the lock. She said the potential risk was someone taking medication off her cart. She said she had been trained on ensuring the medication cart was secured and locked when not in use. During an interview on 08/05/2026 at 3:55 p.m., the DON said the MAs and 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 or on the floor near the medication cart. The DON said an adverse outcome could be a resident or other staff member could obtain the medication off the cart/nearby floor and cause missing medication or unauthorized access or use of the medication. During an interview on 08/05/2026 at 4:20 p.m., the Administrator said he 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 or on the floor near cart unattended because from a safety perspective, someone could come along and take it. Record review of facility policy titled, Medication Administration, dated 10/01/2019, indicated the following: .Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. 2. Administration.P. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained at all times for all resident information (e.g., MAR) by closing the MAR book/covering the MAR sheet or computer screen when not in use. R. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.		

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 08/05/2026
NAME OF PROVIDER OR SUPPLIER Spindletop Hill Nursing and Rehabilitation 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)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 stove in the kitchen reviewed for essential equipment. The facility did not ensure the back center burner on the gas stove ignited when the knob was turned. This failure could place the residents at risk of not having safe operating equipment. Findings included: During an observation and interview on 08/03/2026 at 8:50 a.m., with [NAME] J the stove was checked, 1 of the 6 burners the back center burner did not light when turned on. She said it had not been lighting for about 1 to 2 months. [NAME] J said the cooks were responsible for notifying the DM when equipment did not work. She said there was no resident risk just may take longer to prepare meals. She said she rarely used the back middle burner; she mostly used the ovens and steamer and outer edge burners to prepare food. She denied gas odors. No gas odors on all sides of the stove or anywhere in the kitchen were observed and no hissing sound of gas from the stove observed. During an interview on 08/03/2026 at 9:45 a.m., the Regional Director of Dietary Services said the cooks were responsible for notifying the DM or a manager when equipment did not work and the DM or manager would notify the Maintenance Director so it would be repaired immediately and document the equipment concern in the electronic Maintenance reporting system. She said it was potentially a miscommunication between dietary and maintenance departments. All dietary staff were educated to notify the DM with any equipment not working properly. She said there was no resident risk of the stove burner not working it could possibly slow meal service. She said her expectation was repairs within 24 hours. She said the burner was taken out of service until repaired and there was no smell of gas in the kitchen. The Regional Director of Dietary Services immediately notified the Maintenance Director that the stove burner was not working. During an interview on 08/03/2026 at 10:00 a.m., the DM said the cooks were responsible for notifying her if a burner or any equipment was not working properly. She would notify the Maintenance Director and put the concern in the electronic Maintenance reporting system. She said she worked Monday 07/27/2026 and the back center burner was not lit since 07/20/2026. She lit the pilot light on Monday 07/27/2026 and thought the pilot light had just went out. She said all dietary staff were educated to notify her if any dietary equipment was not working properly. The DM said the potential risk was that meal service may be slower than normal. She said there were no fumes or gas odor in the kitchen when she worked. She said her expectation was all staff would notify her immediately when any dietary equipment was not working properly. During an interview on 08/03/2026 at 10:59 a.m., the Maintenance Director said he was not aware of any problem with the stove until this morning (08/05/2026). He said the cooks were responsible for notifying the DM, the DM would notify him and add it into the electronic reporting Maintenance system. The Maintenance Director said he would check the equipment and repair it, order parts or call a professional to repair it. He said he cleaned the pilot light, but it was still not working, and he called the vendor and ordered a part to repair it. He said there was no resident risk. He could light the pilot light if needed until repaired. During an observation and interview on 08/05/2026 at 8:50 a.m., [NAME] K had been at the facility since March 2026. It was observed the stove burners were checked, the back middle burner did not light immediately. [NAME] K said the cooks were responsible for notifying the DM if equipment was not working properly and she was educated to inform the DM immediately when equipment was not working properly and the DM notified the Maintenance Director and he repaired it. She said she was unsure if she splashed water from eggs this morning and put out the pilot. [NAME] K said the resident risk of a stove burner not lighting was food may not be sent out to the residents timely. She said it worked 3 days ago (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(08/02/2026) when she last worked. She denied any gas smell near the stove or in the kitchen. No gas smells were observed in the kitchen or on any side of the stove. During an interview on 08/05/2026 at 9:00 a.m., the Administrator said the cooks were responsible for notifying the DM if any dietary equipment was not working properly. The DM would notify the Maintenance Director, and he would repair it if possible or order it to be repaired by professionals. He said the dietary staff were all educated to notify the DM if any equipment was not working properly. The Administrator said the resident risk was potentially would take a little longer to prepare meals. He said his expectation was that all equipment be fixed as soon as possible. He said today was the first time he was made aware the stove had a burner not working and the Maintenance Director had checked it and ordered a part to repair it. Record review of in-service dated 08/04/2026 titled, Process for employee . the electronic Maintenance reporting system input for repair services indicated, The electronic reporting Maintenance system in kiosk is located near the employee break rooms. The electronic Maintenance system is also available on all nursing carts and nursing stations and the director's computers have access to the computer application, where the electronic reporting Maintenance system is located. orientation on the proper way to communicate repairs. Record review of Logbook documentation dated 04/08/2026 indicated kitchen rounds stove and oven clean and equipment well-maintained. Record review of an undated facility policy titled, Building Management indicated, . Inspections; Daily, Weekly and Monthly. Expect complete, accurately and on-time. All staff should utilize the electronic reporting Maintenance system .Equipment repairs must be documented with a work order associated with the asset. Expect 100% Completion.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interviews and record review, the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program, for 1 of 23 (MA F) staff reviewed for licensure and training requirements. The facility failed to ensure that MA F had completed the mandatory QAPI training. This failure could place residents at risk of being care for by untrained staff. Record review of personnel records for MA F indicated rehire date of 01/02/2024. Review of the facility's training log, undated, showed no evidence of QAPI training for MA F. Review of the training log for the previous 12 months (08/06/2025 to 08/05/2026) provided by human resources and nursing department indicated no evidence that MA F completed QAPI training. During an interview on 08/05/2026 at 2:15 p.m., HR G said annual required training was computer generated quarterly and staff were provided reoccurring emails regarding required completion and/or the delinquent courses. HR G said the annual training completion was reported to the appropriate department heads each morning Monday through Friday during stand-up meetings. HR G said percentages of completion were reported not delinquent staff. HR G said employees are assigned training quarterly and it was the employee's responsibility to complete training timely, including QAPI in the last quarter of the year. HR G said she should have monitored the employees that were not completing the training timely and reported the delinquent staff to the appropriate department heads for appropriate disciplinary actions. HR G said not completing the annual training as required could lead to missed updates and/or poor performance. An attempted interview on 08/05/2026 at 3:15 p.m. with MA F was unsuccessful, no return call to voicemail and text message. During a group interview on 08/05/2026 at 3:51 p.m., HR H (via phone), DON and the Administrator said the HR department is responsible for reporting the facility staff's completion of the annual computerized training routinely. Requested a policy regarding required annual training. HR H said they did not have a policy regarding annual QAPI training. HR H said facility staff were assigned computer generated training quarterly. HR H said depending on their assigned responsibilities, determined which trainings were assigned. HR H said the facility HR G had access to the computer-generated training completion and delinquent staff. The DON and the Administrator said it was the responsibility of the employees to complete their training on time. The DON and the Administrator said the department heads were responsible for ensuring staff completed the assigned training. The DON and the Administrator said the annual training completion should be monitored closer and delinquent staff should be held accountable like removed from schedule until training completed. The DON stated residents could be at risk for poor quality of care by staff not completing their training. A policy addressing annual employee training was requested from the Administrator, HR G, HR H, and DON on 08/05/2026 at 2:15 p.m. and again on 08/05/2026 at 3:51 p.m. but was not provided prior to exit.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on interviews and record review, the facility failed to provide required Ethics training for 1 of 23 (MA F) staff reviewed for licensure and training. The facility failed to ensure that MA F completed the mandatory Ethics training. This failure could place residents at risk of being cared for by untrained staff. Record review of personnel record for MA F indicated rehire date of 01/02/2024. Record review of the training log for the previous 12 months (08/06/2025 to 08/05/2026) provided by human resources and nursing department indicated no evidence that the MA F completed ethics training. During an interview on 08/05/2026 at 2:15 p.m., HR G said annual required training was computer generated quarterly and staff were provided reoccurring emails regarding required completion and/or the delinquent courses. HR G said the annual training completion was reported to the appropriate department heads each morning Monday through Friday during stand-up meetings. HR G said percentages of completion were reported not delinquent staff. HR G said employees are assigned the training quarterly and it was the employee's responsibility to complete training timely. HR G said she should have monitored the employees that were not completing the training timely and reported the delinquent staff to the appropriate department heads for appropriate disciplinary actions. HR G said not completing the annual training as required could lead to missed updates and/or poor performance. An attempted interview on 08/05/2026 at 3:15 p.m. with MA F was unsuccessful, no return call to voicemail and text message. During a group interview on 08/05/2026 at 3:51 p.m., HR H (via phone), DON and the Administrator said HR department is responsible for reporting the facility staff's completion of the annual computerized training routinely. Requested a policy regarding required annual training. HR H said they did not have a policy regarding annual Ethics training. HR H said facility staff were assigned computer generated training quarterly including ethics in the last quarter of the year. HR H said depending on their assigned responsibilities, determined which trainings were assigned. HR H said the facility HR G had access to the computer-generated training completion and delinquent staff. DON and the Administrator said it was the responsibility of the employees to complete their training on time. DON and the Administrator said the department heads were responsible for ensuring staff completed the assigned training. DON and the Administrator said the annual training completion should be monitored closer and delinquent staff should be held accountable like removed from schedule until training completed. DON stated residents could be at risk for poor quality of care by staff not completing their training. A policy addressing annual employee training was requested from the Administrator, HR G, HR H, and DON on 08/05/2026 at 2:15 p.m. and again on 08/05/2026 at 3:51 p.m. but was not provided prior to exit.		