| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675620 | A. Building<br>B. Wing | 05/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Beaumont Nursing and Rehabilitation | 1175 Denton Dr<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for 4 (Resident #19, Resident #27, Resident #28, and Resident #198) of 7 residents reviewed for respiratory care.<br><br>The facility failed to ensure there were cautionary and safety signs indicating the use of oxygen outside the resident's rooms where oxygen was used.<br><br>These failures placed the residents at increased risk of injury due to fire hazards.<br><br>Findings included:<br><br>Record review of Resident #19's Admission Record dated 5/16/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Type 2 diabetes, hemiplegia, and hemiparesis (paralysis or weakness to one side of the body) following cerebral infarction (stroke), asthma, and history of falling.<br><br>Record review of Resident #19's Order Summary dated 5/16/24 revealed an order dated 5/14/24 that reflected: O2 at 2-4 LPM via nasal cannula [tube used to deliver oxygen through the nose] as needed for shortness of breath or O2 sat [percentage of oxygen saturation in the blood] less than 92%.<br><br>Record review of Resident #19's Treatment Administration Record for the month of May, 2024 reflected he had not been administered oxygen during the month of May.<br><br>Record review of Resident #27's Admission Record dated 5/15/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, asthma, hypertension (high blood pressure), legal blindness, and anxiety.<br><br>Record review of Resident #27's Order Summary dated 5/15/24 revealed an order dated 7/18/23 that reflected: Continuous oxygen @ 2-5L via nasal cannula every shift related to Chronic Obstructive Pulmonary Disease.<br><br>Record review of Resident #27's Treatment Administration Record for the month of May 2024 reflected his oxygen was signed as administered every day.<br><br>(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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #28's Admission Record dated 5/14/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, pressure ulcers, aphasia (language disorder affecting the ability to understand and express language), and pneumonia.<br><br>Record review of Resident #28's Order Summary dated 5/16/24 revealed an order dated 5/14/24 that reflected: May use oxygen at 2-4 LPM via nasal cannula every shift.<br><br>Record review of Resident #28's Treatment Administration Record for the month of May 2024 reflected his oxygen was signed as administered every day except on 5/4/24 when she was out of the facility in the hospital.<br><br>Record review of Resident #198's Admission Record dated 5/16/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including acute pulmonary edema (fluid buildup in the lungs), epilepsy (condition that causes seizures), chronic obstructive pulmonary disease, and cognitive communication deficits.<br><br>Record review of Resident #198's Order Summary dated 5/16/24 revealed an order dated 5/14/24 that reflected: May use oxygen at 2-4 LPM via nasal cannula as needed for shortness of breath or O2 Sat less than 92%.<br><br>Record review of Resident #198's Treatment Administration Record for the month of May 2024 reflected her oxygen was signed as administered every day.<br><br>During an observation on 5/15/24 at 6:35 AM, Resident #28 was observed in her room, sleeping in bed. She was wearing oxygen running at 2 LPM via nasal cannula connected to an oxygen concentrator. There was no sign outside her room indicating oxygen use in her room.<br><br>An observation and interview on 5/15/24 at 12:37 PM revealed Resident #19 was in his room sitting in his wheelchair. An oxygen concentrator was observed in his room with tubing connected. The oxygen was turned off at the time of the observation. Resident #19 stated he used the oxygen when he needed it and had not used it in the past couple of days. There was no sign outside his room indicating oxygen use.<br><br>An observation and interview on 5/15/24 at 12:40 PM revealed Resident # 198 was out of her room. An oxygen concentrator was observed in Resident #198's room with tubing connected and was running at 4 LPM. Resident #198 entered the room during the observation and stated she always used her oxygen while in her room. There was no sign outside her room indicating oxygen use.<br><br>An observation and interview on 5/15/24 at 12:43 PM revealed Resident #27 was sitting up in bed eating lunch. He was wearing oxygen via nasal cannula connected to an oxygen concentrator running at 2 LPM. Resident #27 stated he always wore his oxygen. There was no sign outside his room indicating oxygen use.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/15/24 at 12:49 PM, the DON stated she was responsible for ensuring oxygen signs were posted outside the rooms of residents utilizing oxygen. She stated the signs were important because they didn't want anyone smoking in the rooms and that smoking was not allowed anywhere in the building. The DON stated risks included fire and explosion hazards and posed a safety risk for the residents and entire facility. The DON stated she tried to check for signs as well as weekly tubing changes while doing her daily rounds. She was unsure how she missed the missing signs on the resident's doors.<br><br>During an interview on 5/15/24 at 12:52 PM, the Administrator stated she expected signs indicating oxygen use outside the residents' rooms any time there was oxygen equipment in the room. She identified the Central Supply staff as being responsible for monitoring to ensure there were signs on the doors. She stated she would hope the Charge Nurses, the ADON, and the DON would monitor for signs as well. The Administrator stated there was no smoking allowed in the building, but the signs would remind the nurses to check the residents and ensure they were wearing their oxygen. She stated oxygen could be a hazard if in contact with flammable ointment such as petroleum jelly and stated the main risk was fire.<br><br>During an interview on 5/15/24 at 1:46 PM, the Central Supply Staff stated she did not have any signs related to oxygen use and was not aware that placing signs on resident doors was part of her job duties. She stated the nurses placed the signs because they would know before she did whether the resident was receiving oxygen. She stated she was aware of the requirement for the signs and that it was important to let people know there was oxygen use in the room. She stated there was a risk for fire and oxygen could cause things to blow up.<br><br>In an interview on 5/15/24 at 1:54 PM, LVN D stated she was not aware of the oxygen signs missing from her resident's doors and was not aware she was supposed to be checking for them. She stated the risks of having oxygen running in a room included fire and explosions. She stated she would watch more closely for them in the future.<br><br>During a follow-up interview on 5/15/24 at 2:05 PM, the Central Supply Staff stated she had contacted her consultant for clarification and learned it was her responsibility to order the signs and provide them to the DON and the ADON. She stated she would make sure it was done.<br><br>Record review of the facility's policy and procedure titled, Oxygen Administration dated revised February 13, 2007, reflected the following:<br><br>Oxygen therapy includes the administration of oxygen (02) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. 02 therapy is also prescribed to ensure oxygenation of all body organs and systems . The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse . Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident's bed or concentrator . |