

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Beaumont Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1175 Denton Dr Beaumont, TX 77707	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115</b></p> <p>Based on interview and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 of 5 residents (Resident #1) reviewed for discharge requirements.</p> <p>The facility failed to ensure Resident #1 was readmitted to the facility, after being treated at a behavior hospital.</p> <p>This failure could place discharged residents and residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 09/4/24 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) unspecified severity, without behavioral disturbance, mood disturbance and anxiety, cerebral infarction (stroke), cognitive communication deficit (difficulty with communication), major depressive disorder (serious mental illness), and alcohol abuse.</p> <p>Record review of Resident #1's physician orders dated 07/30/24 indicated to admit Resident #1 to the facility on [DATE], continue orders for 60 days, and he required nursing facility care for 180 days.</p> <p>Record review of Resident #1's discharge MDS dated [DATE] indicated Resident #1's return anticipated, it was an unplanned discharge.</p> <p>Record review of Resident #1's BIMS (dated 03/10/24 from a previous admission) indicated a score of 4 (severe cognitive impairment).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan dated 07/31/24 (revised 08/02/24) indicated he was at risk for wandering. Interventions included distract by offering pleasant diversions, structured activities, food, conversation, television, and books. If Resident #1 was exit seeking, stay with the resident and notify the charge nurse.</p> <p>Record review of Resident #1's care plan dated 07/31/24 (revised 08/02/24) indicated Resident #1 had adjustment issues to admission. Interventions included encourage Resident #1 to participate in conversation with staff and other residents.</p> <p>Record review of Resident #1's care plan dated 07/30/24 indicated he resided on the secure unit related to diagnoses of dementia and risk of elopement. Interventions included involve resident in daily activities.</p> <p>Record review of Nursing Progress note dated 07/31/24 at 2:21 p.m., completed by LVN C indicated Resident #1 pushed LVN C, kicked the exit door which opened and then jumped over the fence and ran along a canal away from the facility.</p> <p>Record review of Residents #1's Nursing Progress Note dated 07/31/24 at 4:01 p.m., completed by ADON D indicated Resident #1 was observed walking down (named street). ADON D attempted to talk to Resident #1 to get him back to the facility. Resident #1 continued under the overpass. Resident #1 continued walking on the feeder road. ADON D stopped his vehicle to block traffic and protect the resident from harm. Resident #1 entered the ADON's vehicle and returned to the facility. He was assessed and vitals were WNL. He had no injuries and no complaint of pain or discomfort.</p> <p>Record review of the Disposition Agreement between the facility and the behavior hospital dated 07/31/24 and signed by ADON D indicated the facility acknowledged they would accept Resident #1 back upon his discharge from the behavior hospital and would not refuse to accept Resident #1.</p> <p>Record review of Residents #1's Nursing Progress Note dated 08/02/24 at 9:43 a.m., completed by ADON D indicated RP was informed Resident #1 was transported from the hospital to the behavior hospital to be evaluated. RP expressed concerns about Resident #1's safety if he returned to the facility. RP agreed Resident #1 would be better placed in a facility that could assist his needs.</p> <p>Record review of Residents #1's Nursing Progress Note dated 09/03/24 at 3:31 p.m., completed by LVN A indicated it was a late entry. On 08/28/24 at approximately 3:30 p.m., LVN A received a call from the behavior hospital and was informed the behavior hospital was trying to give report on Resident #1. LVN A explained the facility would not accept Resident #1 per the administrator. At approximately 6:00 p.m., LVN A received a call from DON B at the behavior hospital who attempted to give report for Resident #1. LVN A explained the Administrator had given LVN A instruction not to accept report on Resident #1 and discharge papers had been sent informing the behavior hospital of his (Resident #1) discharge from the facility. DON B said the facility Administrator had accepted Resident #1 and he was enroute to the facility. LVN A explained to DON B the facility would not accept Resident #1 and he would return to the behavior hospital. At approximately 9:45 p.m., a transport van arrived at the facility and the driver had a container with Resident #1's belongings. LVN A explained the facility would not accept Resident #1. The driver indicated Resident #1 was at the hospital due to attempts to jump out of the van while it was moving. LVN A instructed the driver to return Resident #1's belongings to the behavior hospital and to have her employer notify the behavior hospital of Resident #1's location.</p> <p>(continued on next page)</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Discharge Notification dated 08/28/24, completed by the Administrator, indicated Resident #1 was discharged from the facility on 08/28/24. The reasons for the discharge included 1. The discharge is necessary for the resident's welfare and the resident's needs cannot be met by the facility. 3. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident. 4. The health of individuals in the facility would otherwise be endangered. Due to (Resident #1's) ongoing physical aggression and lack of desire to resident in long term care facilities, the safety and well being of residents and staff is in jeopardy. (Resident #1) is also not safe and is a harm to himself due to his impulsive and aggressive behaviors. (Resident #1) expresses the desire to leave and states that he is not opposed to hurting others to get away.</p> <p>Record review of the Discharge-Unable to Meet Needs Physician/NP/PA Statement signed and dated 08/28/24 by MD J for Resident #1's Discharge Notification indicated 1. What are the specific need the facility cannot meet? Resident aggression, Resident eloped from the facility through secure area. Resident is a danger to other residents and staff of facility. 2. What were the facility efforts to meet those needs? Resident was sent to behavioral hospital. Facility has sent his referral to more than 15 facilities including all men's unit; denied. Resident was only in the facility for less than 24 hours when elopement and aggressions started.</p> <p>Record review of Residents #1's Psychiatric Progress Note from the behavior hospital dated 08/28/24 indicated .(Resident #1) . last PRN med was given on 08/25 and has no need for PRN medication meds since . currently at baseline with no aggression or agitation noted. Discharging Today .</p> <p>Record review of Resident #1's nurse note from the behavior hospital dated 08/28/24 indicated (Resident #1) is ambulating in the hallway, mood is congruent with the (Resident #1's) statement well and good . smiles and speaks when spoken to, denies any anxiety or depression at this time, has not shown an anxiousness, aggression, or combativeness at this time, (Resident #1) is set to discharge back to NH today, all safety needs were met at this time .</p> <p>Record review of Residents #1's Nursing Progress Note dated 08/29/24 at 1:57 a.m., completed by LVN L indicated the hospital ER charge nurse called the NF and reported Resident #1 was being sent back to the NF. The hospital ER charge nurse was informed Resident #1 was discharged from the facility.</p> <p>Record review of Residents #1's Nursing Progress Note dated 08/29/24 at 2:30 a.m., completed by LVN L indicated the hospital ER charge nurse called and stated he spoke with DON B from the behavior hospital and the facility's Administrator had approved Resident #1's return to the facility. LVN L indicated she would have to confirm with the facility's Administrator.</p> <p>Record review of Residents #1's Nursing Progress Note dated 09/03/24 at 3:15 a.m., completed by LVN L indicated the charge nurse from the hospital ER called to send Resident #1 back to the facility. The charge nurse from the hospital ER was informed Resident #1 was discharged from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/24 at 10:45 a.m., the Administrator said Resident #1 was sent to the behavior hospital on 07/31/24 because he eloped from the facility and was a danger to himself and others. She said Resident #1 kicked open the exit door on the secure unit, jumped the 7 foot fence, walked along a canal toward the highway. She said ADON D was able to follow Resident #1 in his truck and then convinced Resident #1 into his truck and returned to the facility. She said the police were called because Resident #1 refused to get out of ADON D's vehicle and go in to the facility. She said Resident #1 indicated he did not want to be in the facility and would hurt someone if he had to in order for him to leave the facility. Resident #1 was transported by the police to the hospital and the hospital wanted to return him to the facility. She said the behavior hospital agreed to admit Resident #1 and picked him up from the hospital on 08/01/24. The administrator said she told the behavior hospital on 08/28/24 that the facility would not take Resident #1 back because his aggressive behaviors were not resolved. She said the behavior hospital continued to call the facility and sent Resident #1 back to the facility after she (the Administrator) had sent Resident #1's Immediate Discharge to the behavior hospital on 08/28/24.</p> <p>During an interview on 09/04/24 at 11:10 a.m., ADON D said he observed Resident #1 walking down (named street) on 07/28/24. He said he attempted to talk to Resident #1 and get him to return to the facility. He said Resident #1 continued to the feeder road and then under the overpass on to the next feeder road toward the highway. He said he blocked traffic with his truck and convinced Resident #1 to get in his truck. He said Resident #1 refused to get out of his truck and enter the facility. He said the police were called to assist. He said Resident #1 got out of truck and was transported to the hospital by the police. He said the behavior hospital agreed to take Resident #1 and transported him to their facility on 08/01/24.</p> <p>During an interview on 09/04/24 at 11:30 a.m., RD M said Resident #1 was not readmitted to the facility due to continued aggression and being a threat to others. He said Resident #1 was ex-military, said he did not want to be in the facility, and threatened to hurt others if he was forced to be in the facility. He said Resident #1's family did not want to be involved or have anything to do with him.</p> <p>During an interview on 09/04/24 at 1:12 p.m., LVN C said Resident #1 was pacing and getting more agitated on 07/31/24. She said the CNA left the secure unit to get ice and soda. She said Resident #1 kicked open the exit door and she attempted to stop his exit. She said she attempted to stop him and grabbed Resident #1's arm. LVN C said Resident #1 flung her against the brick wall, took off and jumped the fence and he was gone. She said she had tried to distract him with activities and TV. She said he never threatened or harmed any of the other residents on the secure unit. She said she called for help immediately and staff went to locate Resident #1.</p> <p>During an interview on 09/04/24 at 1:55 p.m., CNL G said she reviewed Resident #1's chart and he exhibited no aggression or behaviors and it was time for his discharge back to the NF. She said she spoke with the facility Administrator and explained Resident #1's stay at the behavior hospital was over and she said o.k. She said the facility was notified transport was set up and then the facility indicated they would not take Resident #1 back.</p> <p>(continued on next page)</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/24 at 2:11 p.m., Administrator F for the behavior hospital said they agreed to assist with finding alternate placement for Resident #1 but if they were not successful the NF would have to accept Resident #1's return to the NF. She said Resident #1 was assessed as stable and did not require further locked psych level care in the behavior hospital. She said CNL G spoke with the facility Administrator and explained Resident #1's stay at the behavioral hospital was over. She said the NF Administrator said she agreed. She said transportation was arranged for Resident #1's return to the NF.</p> <p>During an interview on 09/04/24 at 2:33 p.m., the Administrator said when she spoke with CNL G on 08/28/24 and was informed the behavior hospital was sending Resident #1 back to the NF, she told them not send him back. She said she did not agree to take him back. She said CNL G said Resident #1 had not had any behaviors for two days and had to return to the facility. The Administrator said she told CNL G to find alternate placement for Resident #1. She said she then completed an immediate discharge notice for Resident #1 on 08/28/24 and sent it to the behavior hospital.</p> <p>During an interview on 09/04/24 at 2:40 p.m., DON E said she took report from the behavior hospital on 08/12/24. She said Resident #1 had continued aggression towards peers and there was no discharge date set.</p> <p>During an interview on 09/05/24 at 8:49 a.m., SW H said Resident #1 resided in the facility for less than 24 hours when he eloped form the secure unit and jumped over the security fence. She said he was discharged to a behavior hospital. She said the behavior hospital was assisting with finding alternate placement but was not successful. She said she had not completed any discharge planning because an alternate placement was not found for Resident #1.</p> <p>During an interview on 09/05/24 at 10:00 a.m., RCN I said she reviewed Resident #1's records from the behavior hospital on 08/28/24. She said she did not feel the facility was a safe place for Resident #1 because he was able to jump the security fence of the secure unit and how close the facility was to the highway. She said she believed Resident #1 was not stable due to continued aggression and had required medications for aggression two days previously at the behavior hospital. She said Resident #1 was issued an immediate discharge from the facility on 08/28/24 and it was sent to the behavior hospital.</p> <p>During an interview on 09/09/24 at 1:42 p.m., DON B said the behavior hospital's discharge planner spoke with the Administrator on 08/14/24 regarding finding placement for Resident #1. He said the facility Administrator was advised Resident #1 would have to return to the facility if no new placement was found. He said he spoke with DON H on 08/19/24 and informed her all the placement referrals were denied and he was asked to send a third referral which he did. DON B said on the 08/27/24 the behavior hospital planned Resident #1's discharge. He said he spoke to the SW H who indicated the facility IDT still had some concerns of Resident #1's behavior from 08/24/24. He said Resident #1 had confusion and disorientation due a UTI. He said he advised SW H he would forward the assessment and notes to the facility. He said he called the facility and the Administrator indicated she was taking over all of Resident #1's discharge planning.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Facility Initiated Discharge Protocol (undated) indicated Perform the following actions: (enter the date completed for each action) Discharge-Unable to Meet Needs-Physician/NP/PA Statement on page 2 completed. If financial discharge only, page 2 is not required. Discharge Notice on page 3 completed. Discharge Notice provided to the following: Resident, Resident Representative, Ombudsman, Other facility-Only required if resident is currently at another facility, i.e. hospital, psych center, etc.</p> <p>Record review of the facility's Discharge Planning Procedure dated 11/28/16 does not include immediate discharge protocols.</p>