

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 10/03/2024
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 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115</p> <p>Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 3 residents (Resident #1) reviewed for hospice services.</p> <p>The facility failed to obtain Resident #1's hospice plan of care, nurse visit notes, and aide visit notes.</p> <p>This failure could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 10/02/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included gastrostomy (an opening in the abdomen and into the stomach to provide nutritional support), breast cancer, diabetes (chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin), unspecified protein calorie nutrition (lack of proper nutrition to absorb nutrients from food), morbid obesity (weight is more than 80-100 pounds above their ideal body weight) due to excessive calories, seizures (sudden, uncontrolled burst of electrical activity in the brain), chronic pain syndrome (persistent pain), end stage heart failure (the heart is too weak to pump blood effectively), chronic embolism (blockage) and thrombosis (blood clots block veins or arteries) of deep veins, contracture (tightening of muscles, tendons, ligaments, skin, and nearby tissues that causes joints to shorten and stiffen), osteomyelitis (bone infection), and chronic kidney disease (kidneys slowly get damaged and can't do important jobs like removing waste and keeping blood pressure normal).</p> <p>Record review of Resident #1's admission MDS dated [DATE] indicated she was sometimes understood and sometimes understood others, had severe cognitive impairment (BIMS-00), and received hospice care.</p> <p>Record review of Resident #1's MDS OSA dated 09/02/24 indicated she was totally dependent on 2+ person physical assist for bed mobility, transfers, and toilet use.</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 0849</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 facility care plan dated 08/27/24 (revised on 08/30/24) indicated she had a terminal prognosis and/or was receiving hospice services from (named hospice provider) for diagnoses of heart disease. Interventions included adjust provision of ADLS to compensate for Resident #1's changing abilities and if receiving hospice services, to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met.</p> <p>Record review of the Order Summary Report dated 08/27 indicated Resident #1 had an order to admit to the facility under care of (named hospice provider).</p> <p>Record review of Resident #1's EHR indicated there was no hospice plan of care, nurse visit notes, and aide visit notes available for review.</p> <p>Record review of the hospice plan of care dated 09/25/24 provided by the Administrator on 10/03/24 indicated there was no communication or coordination of care related to the provision of ADLS and sufficient staff to meet the need of Resident #1 as identified by the facility.</p> <p>During an interview on 10/02/24 at 2:55 p.m., the DON said the administrator was responsible for the residents' medical records. She said if the facility did not have the residents' hospice records, the residents were at risk of not receiving care as required.</p> <p>During an interview on 10/02/24 at 3:27 p.m., RNC A said the facility was responsible to obtain residents' hospice records. She said if the facility did not have the residents' hospice records, the residents were at risk of not receiving care as required.</p> <p>During an interview on 10/03/24 at 4:43 p.m., the Administrator said the hospice providers usually send the residents' plan of care, nurse visit notes, and aide visit notes to the facility monthly. She said she was responsible for residents' medical records and uploading the hospice documents into the EHR. She said (named hospice provider) had not sent Resident #1's care plan, nurse visit notes, or aide visit notes as of 10/02/24. She said she received the hospice care plan on 10/03/24. She said she had not received any hospice nurse visit notes or hospice aide visit notes. She said it was important for the facility to have the hospice documents for the facility to be up to date on the hospice plan of care to ensure coordination of care and ensure residents received care as required.</p> <p>Record review of the facility's Hospice Services policy dated 02/13/07 indicated .11. The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record. At a minimum, the documentation will include: The current and past Texas Medicaid Hospice Recipient Election/Cancellation Form (#3071), Texas Medicaid Hospice-Nursing Facility Assessment Form (#3073), Physician Certification of Terminal Illness (#3074), Medicare Election Statement (if dual eligible), Verification that the recipient does not have Medicare Part A, Hospice Plan of Care, Current interdisciplinary notes to include nurses notes/summaries, physician orders and progress notes, and medications and treatment sheets during the hospice certification period.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Hospice and Nursing Facility Services Agreement dated 04/01/22, indicated, .a. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure the needs of the Hospice patients are met 24-hours per day.Coordination of Services. Hospice shall: . c. Provide Facility with the following information specific to each Hospice Patient residing at the facility: (i) the most recent plan of care; (ii) the hospice election form and any advanced directives; (iii) the physician certification and recertification(s) of illness; (iv) the names and contact information for Hospice staff involved in the care of the patient; (v) Instructions on how to access the Hospice's 24-hour on-call system; (vi) Hospice medication information; and (vii) Hospice physician and attending physician (if any) orders.</p>