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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Nursing and Rehabilitation	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely and housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 10 out of 10 residents in the secure unit reviewed for environment. The facility failed to ensure housekeeping and maintenance services were provided for Resident #4. The facility failed to clean and lock an in-wall storage cabinet in Resident #4's room. The facility failed to ensure the air conditioning was working properly to provide comfortable and safe temperature levels for residents in the secure unit and failed to keep cabinets secured and clean. Temperatures in resident rooms were above 81 degrees F. These failure could place residents at risk of being uncomfortable and being in an institutional environment versus a homelike environment. Findings included: Record review of Resident #4's admission record, dated 05/16/2024, revealed an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with diagnosis that included Alzheimer's Disease. Record review of Resident #4's Quarterly MDS assessment, dated 04/02/2024, revealed a BIMS score of 3, indicating severe cognitive impairment. Observation on 05/14/24 at 9:22 AM in Resident #4's room revealed resident was not in the room, bed was made, and room was clean. Upon entry to the room, the wall on the left had an in-wall cabinet with a latch. The cabinet was not locked and contained 2 black wires going through the ceiling into the side of the wall on the left side, dust, a sleeve of plastic cups, a white plastic mouse trap, what appeared to be rodent droppings, and rolls of wrapping paper. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/15/2024 at 3:41 PM in Resident #4's room, revealed the in-wall cabinet was not locked. The Maintenance Supervisor opened the cabinet doors, stated it was dirty, and it looked like there were pest droppings inside. He said it should be locked and he would put a lock on the cabinet. He stated they used to have old records stored in there. He stated he would get it cleaned and the risk was the residents could catch something from the droppings. Observation and interview on 05/15/224 at 4:05 PM in Resident #4's room, the Administrator looked inside the cabinet and stated there was possible rodent poop. She stated the risk to residents was rodents have diseases. The Administrator stated residents could lock themselves in and the cabinet should have a pad lock for resident safety. She stated there was one other room with a cabinet like this on unit one and it was locked. Record review of Resident #31's admission record, dated 05/16/2024, reveled an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia, congestive heart failure, and chronic kidney disease. Record review of Resident #31's quarterly MDS assessment, dated 04/24/2024 revealed a BIMS score of 3, indicating severe cognitive impairment. Record review of Resident #1's admission record, dated 05/16/2024, revealed a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia, polycythemia vera, and hypokalemia. Record review of Resident #1's quarterly MDS assessment, dated 02/02/2024 revealed no BIMs score. Further review of the MDS revealed Resident #1 usually made self understood and understood others and had moderately impaired cognitive skills for daily decision making. Record review of Resident #248's admission record, dated 05/16/2024, revealed a [AGE] year-old male who admitted on [DATE] with diagnoses that included unspecified dementia, leukemia, type 1 diabetes mellitus, and schizoaffective disorder. Record review of Resident #248's admission MDS assessment, dated 05/08/2024 revealed a BIMS score of 0, indicating severe cognitive impairment. Observation on 05/14/2024 at 08:41 AM in the secure unit revealed 2 large black coolers in the hallway not running. Temperature felt comfortable. Interview on 05/15/2024 at 11:24 AM, the Maintenance Supervisor stated the coil on the AC unit needed to be replaced. He stated they had quotes and were waiting on approval. He said it had been out for about 2 weeks and he had not been monitoring the room temperatures. He stated he would check the thermostat and if it was under 80 degrees it was fine. He said they got 2 big coolers and just today they had installed the small portable AC on the hall to the right [in the secure unit]. Interview on 05/15/2024 at 3:20 PM, the Administrator stated by the end of the day she would know about the AC. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/15/2024 at 3:24 PM, CNA A pushed the ice cart to the secure unit. Upon entry, she stated it was hot back here and it had been like that for 3 days. The temperature felt warm. Observation on 05/15/2024 at 3:24 PM revealed the 2 swamp coolers on in the hall pointed towards the entrance door. The wall thermostat read 74 degrees and one cooler was adjacent to the thermostat. Observation on 05/15/2024 at 3:29 PM, Resident #31 and Resident #1 were in their room. The room felt warm upon entering. Resident #31 was lying in bed with a cover pulled over him. Resident #1 was sitting on the side of bed B facing the window. Resident #31 stated he was not hot, and Resident #1 was not interviewable. Observation and interview on 05/15/2024 at 3:41 PM, the Maintenance Supervisor took the temperature of Resident #4's room. The internal wall was 79 degrees and the outside wall was 83 degrees. The Maintenance Supervisor then took the temperature of Resident #31 and Resident #1's room and the internal wall was 87 degrees, and the outside wall was 91 degrees. He stated the room temperature should not be over 80 degrees. He said the residents should be moved because it was warm. He said he took room temperatures when the unit first went down but had not been taking the temperatures since they purchased the coolers. In an interview on 05/15/2024 at 3:29 PM, LVN B stated the risk to the residents would be they could overheat and dehydrate. She stated the staff were moving the residents to the dining room because it was cooler. Observation on 05/15/2024 at 4:03 PM, the Maintenance Supervisor took the temperature of the dining room, and the interior wall was 78 and the vent was 73 degrees. In an interview on 05/15/2024 at 4:04 PM, the Administrator stated they were taking immediate action and were going to purchase 8 units, one for each resident room. Observation and interview on 05/15/2024 at 4:20 PM, revealed Resident #1 sitting in the TV area, calm and nonverbal. LVN B checked Resident #1's vital signs which were BP 142/67, P 89, and Temporal temp 99.7 degrees. The DON was sitting in the dining room with Resident #31 and stated she checked his BP and P but LVN B checked his temp. A slip of paper with Resident #31's vitals read BP 128/64, P 68, O2 sat 98%, and temp was scribbled out but appeared to have read 99 and 97/1 was written beneath. LVN B stated she was going to recheck because she thought she may have used the thermometer incorrectly. Resident #31's temperature was rechecked and was 99.4 degrees. In an interview on 05/16/2024 at 10:22 AM, the Administrator stated she had been monitoring the room temps in the secure unit but did not document. She stated they knew it was getting warmer but not out of compliance. She stated she would temp during the heat of the day, between 6-7 pm, and would temp the internal walls and the air coming out of the vent. The Administrator stated the regulation was for the temperature to be under 81 and the facility policy was under 80 degrees. She stated they were now monitoring the temps and started when alerted by the State Surveyors. She said they began at 2:45 pm and checked every 2 hours. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/16/2024 at 11:30 AM, the Administrator stated they began getting quotes on either repair or replacement on 04/23/2024 and on 05/07/2024 was when they purchased the 2 big swamp coolers. She stated the staff would say it was really warm on the secure unit. Record review of temperatures from https://www.accuweather.com/en/us/[NAME]/77701/may-weather/331129 revealed the following temperatures in degrees F since 05/07/2024: -05/07/2024 high of 85, low of 76 -05/08/2024 high of 86, low of 77 -05/09/2024 high of 87, low of 78 -05/10/2024 high of 88, low of 68 -05/11/2024 high of 84, low of 66 -05/12/2024 high of 82, low of 65 -05/13/2024 high of 86, low of 66 -05/14/2024 high of 86, low of 64 -05/15/2024 high of 91, low of 63 Record review of screenshot of [store name] receipt revealed 2 swamp coolers were ready for pickup today, Tuesday May 7. Review of screenshot of [store name] receipt revealed 8 Window Air Conditioners were ready for pickup today, Wednesday May 15. Record review of handwritten sheet dated 05/15/2024 with all residents listed and vital signs revealed the following: -Resident #31: BP 107/62, P 79, Temp 98.3, 98.6 and 98.2 -Resident #1: BP 142/67, P 89, Temp 99.7, 99.3, 99.4 -Resident #248: BP 144/77, P 65, Temp 99.8, 98.9, 98.2 Record review of monitoring chart dated 05/15/2024-05/16/2024 revealed the following room temperatures in degrees F: room [ROOM NUMBER]: -82 at 3:00 PM -84 at 5:00 PM (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-74 at 7:00 PM -75 at 9:00 PM -74.4 at 1:00 AM -72.6 at 3:00 AM -72.3 at 5:00 AM -71.1 at 7:00 AM room [ROOM NUMBER]: -82 at 3:00 PM -84 at 5:00 PM -74 at 7:00 PM -74 at 9:00 PM -73.7 at 1:00 AM -72.3 at 3:00 AM -72.8 at 5:00 AM -71.2 at 7:00 AM room [ROOM NUMBER]: -82 at 3:00 PM -84 at 5:00 PM -74 at 7:00 PM -74 at 9:00 PM -74.1 at 1:00 AM -73.7 at 3:00 AM -79.8 at 5:00 AM -73.6 at 7:00 AM (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 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. 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. These failures placed the residents at increased risk of injury due to fire hazards. Findings included: 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. 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%. 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. 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. 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. Record review of Resident #27's Treatment Administration Record for the month of May 2024 reflected his oxygen was signed as administered every day. 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. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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%. Record review of Resident #198's Treatment Administration Record for the month of May 2024 reflected her oxygen was signed as administered every day. 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. 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. 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. 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. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. Record review of the facility's policy and procedure titled, Oxygen Administration dated revised February 13, 2007, reflected the following: 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 .