

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: 675620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER Beaumont Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1175 Denton Street 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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review the facility failed to have qualified professional(s) who was qualified as a therapeutic recreation specialist or an activities professional who was licensed or registered by the State to for 1 of 1 facility reviewed for qualifications of activity professionals. The facility failed to ensure a qualified Activities Professional was in place to direct their activities program for the previous 12 weeks. There was no qualified Activity Director in place from 5/12/2026 and as of 08/12/2026 (date of survey exit). This deficient practice could place residents at risk of not receiving approaches that were individualized to match the skills, abilities, and interests/preferences of each resident for activities. During interviews with ten (10) random residents from 8/10/2026 to 08/12/2026, who wish not to be identified, they stated activities of their interest, like bingo, ice cream socials, group crafts, or visiting musicians have not been offered in the last 2 months. Record Review of the personnel files indicated the facility did not have an activities professional/activities director and the position was open. Record review of Activity Calendars for June and July 2026 did not indicate regularly consistent activities scheduled for the residents. During an interview on 08/12/2026 at 1:40 p.m., the HR D stated she had been in her position since 7/20/2026 and the facility had been seeking to employee an activity director since she acquired the HR responsibilities. During an interview on 08/12/2026 at 1:45 p.m., the CHR E stated she was the facility's corporate human resource, and this was her third week in her position. She said the AD position was open, and the facility was actively seeking a qualified candidate through advertisements, word of mouth and internet job posting. She said the previous AD was employed from 3/31/2026 to 5/12/2026 and the position had been open since her departure. During an interview on 08/12/2026 at 4:23 p.m., the Administrator stated he had interviewed several candidates for the Activity Director position but during interview process found the individuals to be unemployable. He said since he had not found a qualified candidate for the Activity Director position, he was looking at some of his current staff to enroll in the training courses for Activity Director. He stated none of his current staff are registered for the training currently. He said he had volunteers visiting occasionally to assist with activities, but they were not certified. He stated he did not have anyone else who met the Activity Director requirements. He stated it was important to have an Activity Director on staff who met requirements to meet the residents' interests and preferences, and support his or her physical, mental, and psychosocial well-being. Record review of the facility's policy titled Individualized Activity Programs, dated 2011, indicated: The Activity Director and staff will provide individual programming to meet individual needs and interests. Practice Guidelines: 1. The Activity Director determines the need for individual programming through the resident assessment process. (Residents who are in isolation, ordered bed rest, or prefer to not be included in group situations.) 2. Individual programs are developed and implemented regularly consistent with individualized leisure interests and based on the assessment. 3. One-on-one activities are provided regularly for those residents unable or unwilling to (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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attend groups unless otherwise indicated by assessment. 4. Individual programs are coordinated by the Activity Director and documented in the plan of care. 5. Activity Director or Assistant trains and coordinates support staff and volunteers to provide some of the in-room activities for residents. 6. Goals, type of intervention and response are documented and reflected in monthly or quarterly progress notes as required. 7. The Activity Director and Staff regularly (at least quarterly) assess the ability or the interest of the residents to join group activities.		

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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** Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistently with professional standards of practice for 1 of 5 residents reviewed for respiratory care. (Resident #56)The facility failed to ensure Resident #56 received bi-pap for 3 days and not obtaining parameters for the bi-pap machine and oxygen levels to be maintained. This failure could place residents at risk of illness, respiratory complications, and accidents.Findings included: Record review of a face sheet dated 08/10/25 indicated Resident #56 was a [AGE] year old male admitted [DATE] with diagnoses including acute respiratory failure with hypercapnia (a life-threatening condition where the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide from the blood), COPD (chronic lung condition in which the lungs are damaged) and cerebral infarction (when a blood vessel that feeds the brain gets blocked and can affect brain cells) and dependence on supplemental oxygen (your body requires extra oxygen via nasal canula {tube to bring oxygen into someone's nose} to keep blood oxygen levels safely usually above 90%). Record review of Resident #56's electronic records on 08/11/2026 did not indicate an MDS due to his admission on [DATE]. Record review of Resident #56's baseline care plan, initiated on 08/07/2026 did not address supplemental oxygen use or bi-pap use.Record review of Resident #56's Order Summary report dated 08/10/2026 indicated oxygen use at 2 to 4 liters per nasal canula for COPD with a start date of 08/07/2026 with no orders for a bi-pap machine.Record review of Resident #56's Previous Nursing facilities stay physician orders dated 07/10/2026 indicated Bi-pap machine at bedtime and as needed with settings of expiratory positive airway pressure 6 centimeters of water pressure (keeps airways from collapsing when breathe out), Inspiratory Positive Airway Pressure (helps push oxygen into the lungs when breathe in) of 18 per centimeters water, rate of 15 and fraction of inspired oxygen at 35% (the concentration of oxygen a person breathes in). This document was sent to the facility for preadmission assessment.Record review of Resident #56's Summary Report from previous hospitalization on 06/25/2026 indicated he was admitted to a hospital, Respiratory: Managed with supplemental oxygen via nasal cannula (2-3 LPM) to maintain saturations above 90% due to his chronic history of COPD and respiratory failure. Special Monitoring Needs: Frequent monitoring of respiratory status, oxygen saturation, and adherence to Bi-pap therapy at night is critical due to chronic hypercapnic respiratory failure.Equipment . Bi-pap Machine: required for nocturnal use to manage chronic hypercapnic respiratory failure. This document was sent to the facility for preadmission assessment.Record review of Resident #56's hospice orders on 08/07/2026 indicated admitted to hospice services, oxygen at 3 Liters per nasal canula but no order for a bi-pap machine or settings for the bi-pap machine. Record review of Resident #56's Progress Notes indicated on:*08/10/2026 at 2:18 p.m., oxygen saturation of 97%, oxygen at 3/liters per nasal canula, no SOB, no cough, and clear lungs.*08/09/2026 at 7:13 p.m., oxygen saturation 98%, oxygen at 3/liters per nasal canula, no SOB, no cough, and clear lungs. *08/09/2026 at 11:13 p.m., oxygen saturation 97%, oxygen at 3/liters per nasal canula, no SOB, no cough, and clear lungs. *08/09/2026 at 3:13 a.m., oxygen saturation 98%, oxygen at 3/liters per nasal canula, no SOB, no cough, and clear lungs. *08/08/2026 at 2:36 p.m., oxygen saturation 97%, oxygen at 3/liters per nasal canula, no SOB, no cough, and clear lungs. *08/07/2026 at 1:26 a.m., oxygen saturation 97%, oxygen at 3/liters per nasal canula, no SOB, no cough, and clear lungs.Record review of oxygen saturation with oxygen per nasal cannula indicated:*08/12/2026 11:14 a.m., 94%;*08/11/2026 12:25 p.m., 94%;*08/11/2026 12:24 p.m., 94%;*08/11/2026 8:54 a.m., 96%;*08/10/2026 4:32 p.m., 97%;*08/10/2026 4:31p.m., 97%;*08/10/2026 (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 08/11/26 at 11:20 a.m., the ADON said she was the nurse that admitted Resident #56, he came from home, brought his own medication, boxes and boxes of stuff, an electric wheelchair, and the bi-pap machine. She said she did not see the paperwork from the hospital. The ADON said Hospice RN C was at the facility and she received orders for the resident but did not receive orders for the bi-pap machine. The ADON said Resident #56 did not say anything about how he used the bi-pap machine. She said she was aware he came from another facility then went home and was admitted into this facility from home. The ADON said Resident #56 was alert and orientated and could tell you, his needs. She said she did not get any orders for the bi-pap machine; she was unaware Hospice RN C did not write an order for the bi-pap machine or settings. The ADON said the nurse admitting the resident was responsible for ensuring there were orders for all equipment. She said she should have gotten orders for the bi-pap machine. The ADON said all resident records were uploaded into a resident's chart. She was educated in the admission process, and all medication and equipment needed orders. The ADON said Resident #56 arrived at the end of her shift and she did not ask if he had equipment or if it worked. She said Resident #56 said he said he applied the bi-pap machine himself when he went to bed. The ADON said herself and the DON ensured orders are completed the next business day. Which was today 08/10/2026. She said the potential resident risk of not having orders and not using the bi-pap machine was potentially respiratory concerns. She did not review the notes in the miscellaneous records. During an interview on 8/11/2026 at 12:30 p.m., the DON said she reviewed Resident #56's paperwork and was aware he had a bi-pap machine on admission. She said the Marketer said he was bringing it from home. The DON said Resident #56 was hospice resident and she assumed he would bring the bi-pap machine from home and hospice would write orders for it. She said she was not here when Resident #56 admitted and was not told hospice did not write orders for it. She said the corporate nurse in the facility was making rounds and notified her there were no orders for the bi-pap machine. The DON said her expectation of the Weekend supervisor was to make sure staff was doing what they are supposed to do and not work on admissions. The DON said her expectation was the nurse starting the admission to complete the admission, check all admission paperwork. She said they should call hospice or the staff on call with any issues. She said if the nurse did not finish the admission, the next shift will finish it. The DON said the bi-pap machine should have orders for it and it should have been working. She was made aware he was on bi-pap machine when she accepted him a month ago. The DON said she put Resident #56's medication orders in Friday prior to admission, but did not activate. She said she did not have settings for the bi-pap machine. She said the settings were usually received from the hospital. The DON said his machine was preset. She thought it would be in the admission orders. The DON said the potential negative outcome of not getting orders and not putting on bi-pap machine was respiratory issues. The DON said no one notified her this weekend to tell there was a bi-pap machine without orders and not working. She said the ADON had access to Resident #56's records uploaded in the chart. The DON said for new admissions she reviewed information, made staff aware of admission and needs. She said she was responsible for making sure staff were aware of needed equipment and care. The DON said the facility had backup equipment to replace non-working equipment, but she was not aware Resident #56's bi-pap machine was not working and that he went without it for 3 nights. The DON said her expectation if a resident has a bi-pap machine, had orders, make sure it functioned properly and staff help put it on the resident. She said Resident #56 was only resident on a bi-pap machine in the facility at this time. During an interview on 08/10/2026 at 1:00 p.m., LVN A said she was responsible for providing care for Resident #56 this morning (08/10/2026). She said she saw him this morning on rounds. He was up in his bed. She said he had so many contraptions in his room She was unaware he (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was on a bi-pap machine. LVN A said Resident #56 had no dizziness, or hallucination but was slightly SOB after therapy. Resident #56 was wearing oxygen at 3 liters per nasal cannula. She gave him a breathing treatment at 8:00 a.m., and 11:00 a.m. She said his pulse ox was 97 % before and after both treatments. He had oxygen on. Resident #56 did not mention the bi-pap machine not used or not working to her. LVN A said she did not ask about orders for a bi-pap machine because she was unaware of it. She did not see a bi-pap on the 24-hour report. LVN A said she had been trained in the use of a bi-pap machine and how to set it up and put it on the resident. She said the DME supplier educated the staff on settings when a resident had a bi-pap machine. She said the Admissions person was responsible for ensuring all equipment for the resident was at the facility, had orders and was working and the DON was the back up. LVN A said the potential resident risk of not having orders for a Bi-pap machine and the equipment not working was a potential respiratory complication. During an interview on 08/10/2026 at 4:40 p.m., The Administrator said Hospice RN C was responsible for ensuring orders for the bi-pap machine for Resident #56 were completed in the resident's chart. The backup was the ADON and DON the next business day (08/10/2026) would review the chart and resident and ensure there were orders for all equipment and all equipment was working. He said the admission nurse was responsible for inspecting and verifying all equipment was in proper working condition and all services and orders were administered. The Administrator said all nurses were in-serviced with routine in-services on areas of concern and suggested concerns. He said the resident risk of no orders for the bi-pap machine and not receiving it would depend on the acuity level of the resident. He said Resident #56 was low risk of potential complications. The Administrator said his expectation was nurses to input all needed orders, inspect and verify all equipment was in proper working order and residents receive all needed services, all nurses be aware of all resident needs and notify administrative nurses of needs. If a resident brought his own equipment staff be aware of it. He said he approved all orders for any needed equipment if the resident's equipment was not effective. During an interview on 08/11/2026 at 12:51 p.m., LVN B said she was responsible for providing care for Resident #56, Sunday (08/09/2026). She said she saw a lot of mechanical apparatus but did not look too close to see what they were. She said she was not aware Resident #56 had a bi-pap machine and did not see any orders for it. She said she did give him a breathing treatment. LVN B said she was educated on how to apply a bi-pap machine and had worked with some previously. She said Resident #56 did not mention the bi-pap machine or having problems with the bi-pap machine. She said the potential risk of equipment not working and not using a bi-pap machine for 3 days was it could be a risk depending on the resident's condition. LVN B said it could possibly worsen his condition. During Phone calls on 08/12/2026 at 7:00 a.m., message left to LVN G that provided care to Resident #56 on 08/08/26 and 08/09/2026 doubles to return call related to an incident. LVN G did not return call. Record review of an undated facility policy titled, General Administration CPAP/ Bipap indicated, Bipap is the application of positive airway pressure that varies in magnitude during inspiration {breathing in} and expiration {breathing out}. Two pressure settings; one for inspiratory and lower setting for expiratory. Procedure: 1. Position mask on resident. 2. Secure mask by pulling the straps tight enough to allow minimal leak. 5. Press the ON button on the Bipap and the machine will begin delivering air pressure per the physician orders. If pressure setting are to be changed, the facility change the settings per the physician orders. 9. If the machine is not operating correctly, the supplying DME company is to be contacted immediately. It did not indicate orders required.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop the baseline care plan within 48 hours of admission for 1 of 17 residents (Resident #56) reviewed for baseline care plans. The facility failed to ensure Resident #56's baseline care plan was completed within 48 hours of admission on to include oxygen administration and bi-pap (a non-invasive medical device that helps people breathe by delivering two alternating pressure levels a higher pressure when you breathe in and lower pressure when you breathe out) machine use. This failure could place residents at risk of not having needs met Findings included: Record review of a face sheet dated 08/10/25 indicated Resident #56 was a [AGE] year old male admitted [DATE], diagnoses included acute respiratory failure with hypercapnia (a life-threatening condition where the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide from the blood), COPD (chronic lung condition in which the lungs are damaged) and cerebral infarction (when a blood vessel that feeds the brain gets blocked and can affect brain cells) and dependence on supplemental oxygen (your body requires extra oxygen via nasal canula to keep blood oxygen levels safe usually above 90%). Record review of Resident #56's electronic records on 08/11/2026 did not indicate an MDS due to his admission on [DATE]. Record review of Resident #56's baseline care plan, initiated on 08/07/2026 did not address supplemental oxygen use or bi-pap use. Record review of Resident #56's Order Summary report dated 08/10/2026 indicated oxygen use at 2 to 4 liters per nasal canula for COPD with a start dated of 08/07/2026 with no orders for bi-pap machine. During an observation and interview on 08/10/2026 at 10:25 a.m., Resident #56 was sitting in his wheelchair wearing oxygen at 3 liters per nasal canula. He had no observed shortness of breath and his respirations even and unlabored. He denied being short of breath. He said he used the bi-pap machine every night for 5 to 6 hours. During an interview on 08/10/25 at 1:00 p.m., LVN A said she was responsible for providing care for Resident #56 today (08/10/2026) day shift. She said he was receiving oxygen therapy, but she was unaware he was on a bi-pap machine. During an interview on 08/11/26 at 11:20 a.m., the ADON said she was the nurse that admitted Resident #56 and was responsible for opening the 48-hour baseline care plan. She said the DON or MDS nurse would complete it the next business day. She said she initiated the baseline care plan but did not add oxygen use or bi-pap to the 48-hour baseline care plan. The ADON said the potential resident risk was that staff may not be aware of all the resident's needed care. During an interview on 8/11/2026 at 12:30 p.m., the DON said the nurse that admitted a (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was responsible for initiation of the 48-hour baseline care plan. She said the MDS nurse and DON triggered the baseline care plan the next business day. The DON said the ADON did not trigger, view all in the computer system and trigger all items that would have completed the 48-hour care plan. She said she did review Resident #56's information on Monday (08/10/2026) and completed the comprehensive care plan. The DON said there was no resident risk due to the staff having orders to follow except for the bi-pap and no care would be missed. The DON said her expectation was the admitting nurse completely trigger all items on the 48-hour care plan to address all resident needs. During an interview on 8/11/2026 at 1:30 p.m., the Administrator said the admitting nurse was nurse was responsible for initiating the baseline care plan. He said the DON and Administrator were responsible over site of pertinent information. He said the staff were educated on completion of baseline care plans. The Administrator said the ADON initiated the baseline care plan but did not populate with all information. He said the resident risk was low due to nursing follow up on next business day. The Administrator said his expectation of 48-hour care plans was initiated within 48 hours of admission and followed up on next business day by the DON and ADON. Record review of an undated facility policy titled, Base Line Care Plans indicated, . This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The baseline care plan will &ndash; be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including but not limited to- initial goals based on admission orders, physician orders. It will be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, .documents the interim approaches for meeting the resident's immediate needs, .		

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NAME OF PROVIDER OR SUPPLIER Beaumont Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1175 Denton Street Beaumont, TX 77707	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #11) of 17 residents reviewed for care plans. The facility failed to care plan Resident #11's external male catheter with urine collection system (uses suction to pull urine through tubing to the connected collection canister) when he admitted on [DATE] with an urine collection system. This failure could affect residents by placing them at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #11's admission record indicated a [AGE] year-old male admitted on [DATE] with diagnosis of anxiety disorder (persistent and excessive worry that interferes with daily activities), chronic pain syndrome (a condition where ongoing physical pain lasts past three to six months), scoliosis (a medical condition that causes the spine to curve sideways), and end stage heart failure (most severe phase of the disease where the heart can no longer pump well). Record review of Resident #11's admission MDS assessment, dated 06/08/2026, indicated a BIMS score of 13 indicating Resident #11 was cognitively intact with little to no impairment. He was dependent on staff for toileting and personal hygiene. He was always incontinent. Record review of the comprehensive care plan for Resident #11 with print date of 08/10/2026 indicated no care plan for the external catheter urinary wicking system. The care plan indicated he was incontinence with bladder. The interventions included providing incontinent care at least every 2 hours and applying moisture barrier after each episode and no mention of the external catheter urinary wicking system. The care plan did not address who would reapply the external catheter urinary wicking system, empty the canister, when and frequency needed. During an interview and observation on 8/10/26 at 2:00 p.m., Resident #11 said he used the external catheter urinary wicking system. He said he pays for the supplies himself and had been doing this for a long time at home. He said he ordered containers and bags as he pointed across his room to boxes. On the floor next to the bed were 2 urine collection containers. One of the containers was full of dark yellow urine. He said he needed assistance with the setting up of the system and for bag to be reapplied as needed. During an interview on 08/11/2026 at 4:00 p.m., DON said the hospice nurse applied the external catheter urinary wicking system weekly on Mondays. The DON said there were no orders or documentation for it being changed. The DON said the external catheter urinary wicking system should have been addressed on Resident #11's care plan to ensure care and services on admission were provided to assist him with assistance as was needed. She said there was no policy for the external catheter urinary wicking system. She said the CNAs or the nurses should assist with emptying the container. During an observation and interviews on 08/11/2026 at 4:10 p.m., Resident #11 said the bag had been off since yesterday, then he told the DON the bag just came off. The DON and Regional nurse were changing his brief, and bag was not seen in the brief or in the bed. The DON and Regional Nurse finished cleaning Resident #11 and they applied the external catheter urinary wicking system.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 1 of 17 residents (Resident #11) reviewed for activities.The facility failed to provide Resident #11 in room activities since his admission on [DATE]. This failure could place residents at risk for boredom, depression, and a diminished quality of life. Findings included:Record review of Resident #11's admission record indicated a [AGE] year-old male admitted on [DATE] with diagnosis of anxiety disorder (persistent and excessive worry that interferes with daily activities), chronic pain syndrome (a condition where ongoing physical pain lasts past three to six months), scoliosis (a medical condition that causes the spine to curve sideways), and end stage heart failure (most severe phase of the disease where the heart can no longer pump well).Record review of Resident #11's admission MDS assessment, dated 06/08/2026, indicated a BIMS score of 13 indicating Resident #11 was cognitively intact with little to no impairment. The following activities were somewhat important to Resident #11: doing his favorite activity, listening to music, and keeping up with the news.Record review of Resident #11's Comprehensive Care Plan, dated 07/30/2025, indicated to provide a program of activities that is of interest and accommodates. The goal was to be satisfied with activities and be assisted to attend activity functions.During an interview on 08/10/2026 at 9:39 a.m., Resident #11 said he stayed in bed and did not have in-room activities. He said when he first got here someone talked to him about his preferences of activities. He said he would like a word search book, and he had not told anyone. During an interview on 08/10/26 at 3:00 p.m., the Administrator said he had just hired a part-time person. and was looking for in-room activity logbook from the previous activity director. During an interview on 08/12/2026 at 9:00 a.m., the Administrator said he expected the ADs to provide in-room activities and could not find the log of the in-room activities. He said he would provide policy on activities. During an interview on 08/12/2026 at 1:45 p.m., the CHR E stated she was the facility's corporate human resource, and this was her third week in her position. She said the AD position was open, and the facility was seeking a qualified candidate. She said the previous AD was employed from 3/31/2026 to 5/12/2026 and the position had been open since her departure.Record review of the facility's policy titled Individualized Activity Programs, dated 2011, indicated: The Activity Director and staff will provide individual programming to meet individual needs and interests. Practice Guidelines: 1. The Activity Director determines the need for individual programming through the resident assessment process. (Residents who are in isolation, ordered bed rest, or prefer to not be included in group situations.) 2. Individual programs are developed and implemented regularly consistent with individualized leisure interests and based on the assessment. 3. One-on-one activities are provided regularly for those residents unable or unwilling to attend groups unless otherwise indicated by assessment. 4. Individual programs are coordinated by the Activity Director and documented in the plan of care. 5. Activity Director or Assistant trains and coordinates support staff and volunteers to provide some of the in-room activities for residents. 6. Goals, type of intervention and response are documented and reflected in monthly or quarterly progress notes as required. 7. The Activity Director and Staff regularly (at least quarterly) assess the ability or the interest of the residents to join group activities.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the appropriate care and services to prevent urinary tract infections to the extent possible for 1 of 1 resident (Resident #11) reviewed for external catheters. The facility failed to ensure physician orders for the external male catheter with a urine collection system (used suction to pull urine through tubing to the connected collection canister) for Resident #11 when he admitted on [DATE]. This failure could place residents at risk of not receiving care and services and could cause decline in conditions. Findings included: Record review of Resident #11's admission record indicated a [AGE] year-old male admitted on [DATE] with diagnosis of anxiety disorder (persistent and excessive worry that interferes with daily activities), chronic pain syndrome (a condition where ongoing physical pain lasts past three to six months), scoliosis (a medical condition that causes the spine to curve sideways), and end stage heart failure (most severe phase of the disease where the heart can no longer pump well). Record review of an admission telephone order dated 05/27/2026 indicated no order or instructions for the external catheter urinary wicking system. Record review of Resident #11 physician's orders dated August 2026 indicated no orders or instructions for the external catheter urinary wicking system. Record review of Resident #11's admission MDS assessment, dated 06/08/2026, indicated a BIMS score of 13 indicating Resident #11 was cognitively intact with little to no impairment. He was dependent on staff for toileting and personal hygiene. He was always incontinent. Record review of the comprehensive care plan for Resident #11 with print date of 08/10/2026 indicated no care plan for the external catheter urinary wicking system. The care plan indicated he was incontinent with bladder. The interventions included providing incontinent care at least q2h and apply moisture barrier after each episode and no mention of the external catheter urinary wicking system. The care plan did not address who would reapply the external catheter urinary wicking system, empty the canister, when and frequency needed. During an interview and observation on 8/10/26 at 2:00 p.m., Resident #11 said he used the external catheter urinary wicking system. He said he pays for the supplies himself and had been doing this for a long time at home. He said he ordered containers and bags as he pointed across his room to boxes. On the floor next to the bed were 2 urine collection containers. One of the containers was full of dark yellow urine. He said he needed assistance with the setting up of the system and for bag to be reapplied as needed. During an interview on 08/11/2026 at 4:00 p.m., DON said the hospice nurse applied the external catheter urinary wicking system weekly on Mondays. The DON said there was no documentation for it being changed. The DON said the external catheter urinary wicking system should have been addressed on Resident #11's physician's orders to ensure care and services were provided to assist him with assistance as needed. She said there was no policy for the external catheter urinary wicking system. During an observation on 08/11/2026 at 4:10 p.m., Resident #11 said the bag had been off since yesterday, then he told the DON the bag just came off. The DON and Regional nurse were changing his brief, and bag was not seen in the brief or in the bed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel for 1 of 17 residents (Resident #11) reviewed for storage and labeling of medications. The facility failed to ensure Resident #11 did not have medications Neosporin and prescribed miconazole 2% (anti-fungal cream) at the bedside. These failures could place residents at risk for misuse of medication, overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications. The findings include: Record review of Resident #11's face-sheet indicated he was a [AGE] year old male, admitted to facility on 05/27/26. His diagnosis included: hypertension, heart Failure, schizoaffective disorder bi-polar type, chronic pulmonary edema, anxiety disorder and adult failure to thrive. Record review of Resident #11's admission MDS dated [DATE] indicated in the resident is usually understood or usually understands others and had clear speech and had a BIMS of 13 which indicated the resident was cognitively intact for decision making. Record review of Resident #11's electronic record on 08/11/26 indicated there was no Care Plan addressing the resident may keep medications at bedside or to self-administer medications. Record review of the electronic record on 08/11/26 indicated Resident #11 did not have a Self-Administration Medication Assessment initiated or completed. Record review of Resident #11's consolidated report of current Physician orders dated 8/2026 indicated no scheduled or PRN order for Neosporin or prescribed miconazole 2% ointment, self-administer medications or to leave at bedside. Observation during initial tour, on 08/10/26 at 9:30 a.m., Resident #11 was in the room and the door was open. On his bedside table was an opened and used 1-ounce tube of Neosporin with no pharmacy label. On the bedside nightstand was an opened and used tube of prescription labeled miconazole 2% ointment. Observations and interview on 08/11/26 at 10:00 a.m., Resident #11 was in his room laying in his bed. When asked where does he put the Neosporin and how often does he use it? Resident #11 said that he uses Neosporin on his groin whenever it's dry and to keep infection from starting and that he ordered it from Amazon approximately 2 weeks ago. Resident #11 further said he used the prescribed miconazole 2% ointment on his feet to help with itching and the nurses left it in the room one day, but he couldn't remember when. Resident #11 said he had not notified the nurses about the medications because he was not aware that he had to tell them since the medications were over-the-counter medications. Resident #11 also said he did not report it to the nurses because the areas cleared up and didn't see any point in it. Resident #11 also said no one from the facility had contacted him about the medications, or that they could not be left out unattended at the bedside. When asked if he stored the medications in a different area Resident #11 said I keep it out like that very much like you see it there is not much room here to put things. During an interview on 08/10/2026 at 10:10 a.m., LVN-A said she had assessed Resident #11 this morning and had not noticed any medications left out at his bedside. LVN-A said no residents should have medications at their bedside. She said she did not know of any residents having medications in their rooms. She said a physician's order must be on file for the resident to receive the medication as well as to self-administer medications. She said a resident could take inappropriate amounts of the medication or another resident could wander in the room and get the medication and take it. She said residents could have an allergic reaction or become ill from taking unprescribed medication. During an interview on 08/10/26 at 10:18 a.m., CMA-H said she had administered medication to Resident #11 this morning (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but had not noticed any medication left at the bedside. CMA-H said she's not aware of any resident having medications in their room. She said a resident can make themselves sick by taking unprescribed medications. She said all medications must have a physician's order and be given by a nurse or medication aide. Interview on 08/11/26 at 11:20 a.m., the DON said she was not aware of the medications at Resident #11's bedside. The DON said her expectation is for nursing staff to follow facility policy and procedure and not leave medications at the bedside. The DON said Resident #11 would need a doctor's order and medication self-administration assessment completed before he would be able to keep meds at the bedside and administer them himself. The DON revealed she would have to look in the computer to see if Resident #11 had an order or med assessment, after looking in the computer the DON stated to surveyor that Resident #11 did not have an order for medications Neosporin and prescribed miconazole 2% or to leave medications at bedside and no self-administer medication assessment had been done for Resident #11. The DON said leaving medications at the bedside puts residents at risk of not taking them properly or giving them to someone else to take, but that she (DON) felt Resident #11 was cognitively intact enough to take the medication correctly and would need to have a MD order or Self-Med Assessment first. The DON agreed that residents in the facility must have a doctor's order to receive medications and that no resident can keep medication in their rooms and are not allowed to self-medicate. She stated there must be a physician's order to leave the medication at the bedside and an order for the resident to self-medicate. Review of the facility's undated policy titled, Self-Administration of Medication by Resident indicated, in part: .2. If the resident desires to self-administer medications an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility. 3. The interdisciplinary team determines the residents' ability to self-administer medications by means of completing the Self Administration of Medication assessment in PCC. 4. The results of the interdisciplinary team assessment are recorded. 5. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if unlocked storage is ineffective. Adhere to the State Health Departments Rules on this matter b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the supplying pharmacy. Adhere to the individual State Health Departments rules as it relates to documentation for a resident that self-administers medications. 6. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and then give unauthorized medications to the charge nurse for return to the family or responsible party .		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interviews and record review, the facility failed to provide required effective communications training for direct care staff for 1 of 23 (PT F) staff sampled for licensure and training. The facility failed to ensure that PT F had completed the mandatory effective communication training. This failure could place residents at risk of being cared for by untrained staff. Record review of personnel record for PT F indicated a hire date of 01/31/2025. Review of the facility's training log, undated, showed no evidence of effective communication training for PT F. Record review of the training log for the previous 12 months (08/12/2025 to 08/12/2026) provided by human resources department indicated no evidence that PT F completed effective communication training. During an interview on 08/12/2026 at 1:42 p.m., HR D stated she was newly appointed to the facility HR position and was currently being training on her job duties, which will include reviewing and reporting annual training but currently did not have access to view or run reports regarding annual training completion in the computerized training system. Said PT F was a shared employee with another sister facility and was currently on vacation out of the country. During an interview on 08/12/2026 at 1:48 p.m., CHR E said annual required training was computer generated quarterly and staff were provided emails regarding required completion and/or the delinquent courses. CHR E said the annual training completion was reported to the appropriate department heads routinely. CHR E said percentages of completion and delinquent staff were included in the report. CHR E said employees are assigned training quarterly and it was the employee's responsibility to complete training timely, including effective communication training. She said ultimately the HR department, including herself, was responsible for monitoring employees that were not completing the required training timely and reporting the delinquent staff to the appropriate department heads for appropriate disciplinary actions. CHR E said both the facility HR and department head (director of rehabilitation) responsible facility staff were newly employed or recently appointed to the position and both in training and learning their job responsibilities. CHR E said staff not completing the annual training as required could lead to missed updates and/or poor performance. An attempted interview on 08/12/2026 at 3:15 p.m. with PT F was unsuccessful, no return call to voicemail and text message. During a group interview on 08/12/2026 at 4:15 p.m., 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. He said the facility HR staff was new to her position and was being provided with access and training in the monitoring and reporting of the computer-generated training completion and delinquent staff. He said PT F was a shared employee with another sister facility which was the primary facility for assigning computerized training. He said PT F had not completed his assigned computerized training on effective communication and he was unable to provide required training due to assigned training not being completed. He said it was the responsibility of the employees to complete their training on time. He said the department heads were responsible for ensuring staff completed the assigned training and the annual training completion should be monitored closer and delinquent staff should be held accountable. He said he completed random checks on annual trainings completion. He stated not completing the annual effective communication training as required could lead to employees not receiving updates or changes necessary for proper communication. A policy addressing annual employee training was requested from the Administrator and CHR E, on 08/12/2026 at 3:00 p.m. but was not provided prior to exit.		

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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 provide required Quality Assurance Performance Improvement (QAPI) training that outlines and informs staff of the elements and goals of the facility's QAPI program, for 1 of 23 (PT F) staff sampled for licensure and training. The facility failed to ensure that PT F had completed the mandatory QAPI training. This failure could place residents at risk of being cared for by untrained staff. Record review of personnel record for PT F indicated a hire date of 01/31/2025. Review of the facility's training log, undated, showed no evidence of QAPI training for PT F. Record review of the training log for the previous 12 months (08/12/2025 to 08/12/2026) provided by human resources department indicated no evidence that PT F completed QAPI training. During an interview on 08/12/2026 at 1:42 p.m., HR D stated she was newly appointed to the facility HR position and was currently being training on her job duties, which will include reviewing and reporting annual training but currently did not have access to view or run reports regarding annual training completion in the computerized training system. Said PT F was a shared employee with another sister facility and was currently on vacation out of the country. During an interview on 08/12/2026 at 1:48 p.m., CHR E said annual required training was computer generated quarterly and staff were provided emails regarding required completion and/or the delinquent courses. CHR E said the annual training completion was reported to the appropriate department heads routinely. CHR E said percentages of completion and delinquent staff were included in the report. CHR E said employees are assigned training quarterly and it was the employee's responsibility to complete training timely, including QAPI training. She said ultimately the HR department, including herself, was responsible for monitoring employees that were not completing the required training timely and reporting the delinquent staff to the appropriate department heads for appropriate disciplinary actions. CHR E said both the facility HR and department head (director of rehabilitation) responsible facility staff were newly employed or recently appointed to the position and both in training and learning their job responsibilities. CHR E said staff not completing the annual training as required could lead to missed updates and/or poor performance. An attempted interview on 08/12/2026 at 3:15 p.m. with PT F was unsuccessful, no return call to voicemail and text message. During a group interview on 08/12/2026 at 4:15 p.m., 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. He said the facility HR staff was new to her position and was being provided with access and training in the monitoring and reporting of the computer-generated training completion and delinquent staff. He said PT F was a shared employee with another sister facility which was the primary facility for assigning computerized training. He said PT F had not completed his assigned computerized training on QAPI and he was unable to provide required training due to assigned training being not completed. He said it was the responsibility of the employees to complete their training on time. He said the department heads were responsible for ensuring staff completed the assigned training and the annual training completion should be monitored closer and delinquent staff should be held accountable. He said he completed random checks on annual trainings completion. He stated not completing the annual QAPI training as required could lead to employees not receiving updates or changes necessary and facility QAPI goals. A policy addressing annual employee training was requested from the Administrator and CHR E, on 08/12/2026 at 3:00 p.m. but was not provided prior to exit.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interviews and record review, the facility failed to provide infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program, for 1 of 23 (PT F) staff sampled for licensure and training. The facility failed to ensure that PT F had completed the mandatory infection prevention and control program training. This failure could place residents at risk of being cared for by untrained staff. Record review of personnel record for PT F indicated a hire date of 01/31/2025. Review of the facility's training log, undated, showed no evidence of infection prevention and control program training for PT F. Record review of the training log for the previous 12 months (08/12/2025 to 08/12/2026) provided by human resources department indicated no evidence that PT F completed infection prevention and control program training. During an interview on 08/12/2026 at 1:42 p.m., HR D stated she was newly appointed to the facility HR position and was currently being training on her job duties, which will include reviewing and reporting annual training but currently did not have access to view or run reports regarding annual training completion in the computerized training system. Said PT F was a shared employee with another sister facility and was currently on vacation out of the country. During an interview on 08/12/2026 at 1:48 p.m., CHR E said annual required training was computer generated quarterly and staff were provided emails regarding required completion and/or the delinquent courses. CHR E said the annual training completion was reported to the appropriate department heads routinely. CHR E said percentages of completion and delinquent staff were included in the report. CHR E said employees are assigned training quarterly and it was the employee's responsibility to complete training timely, including infection prevention and control program training. She said ultimately the HR department, including herself, was responsible for monitoring employees that were not completing the required training timely and reporting the delinquent staff to the appropriate department heads for appropriate disciplinary actions. CHR E said both the facility HR and department head (director of rehabilitation) responsible facility staff were newly employed or recently appointed to the position and both in training and learning their job responsibilities. CHR E said staff not completing the annual training as required could lead to missed updates and/or poor performance. An attempted interview on 08/12/2026 at 3:15 p.m. with PT F was unsuccessful, no return call to voicemail and text message. During an interview on 08/12/2026 at 4:15 p.m., 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. He said the facility HR staff was new to her position and was being provided with access and training in the monitoring and reporting of the computer-generated training completion and delinquent staff. He said PT F was a shared employee with another sister facility which was the primary facility for assigning computerized training. He said PT F had not completed his assigned computerized training on infection prevention and control program training and he was unable to provide required training due to assigned training not being completed. He said it was the responsibility of the employees to complete their training on time. He said the department heads were responsible for ensuring staff completed the assigned training and the annual training completion should be monitored closer and delinquent staff should be held accountable. He said he completed random checks on annual trainings completion. He stated not completing annual infection control training as required could lead to employees not receiving updated or changed infection control information. A policy addressing annual employee training was requested from the Administrator, CHR E, on 08/12/2026 at 3:00 p.m. but was not provided prior to exit.		

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 08/12/2026
NAME OF PROVIDER OR SUPPLIER Beaumont Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1175 Denton Street 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 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 (PT F) staff sampled for licensure and training. The facility failed to ensure that PT F had 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 PT F indicated a hire date of 01/31/2025. Review of the facility's training log, undated, showed no evidence of ethics training for PT F. Record review of the training log for the previous 12 months (08/12/2025 to 08/12/2026) provided by human resources department indicated no evidence that PT F completed ethics training. During an interview on 08/12/2026 at 1:42 p.m., HR D stated she was newly appointed to the facility HR position and was currently being training on her job duties, which will include reviewing and reporting annual training but currently did not have access to view or run reports regarding annual training completion in the computerized training system. Said PT F was a shared employee with another sister facility and was currently on vacation out of the country. During an interview on 08/12/2026 at 1:48 p.m., CHR E said annual required training was computer generated quarterly and staff were provided emails regarding required completion and/or the delinquent courses. CHR E said the annual training completion was reported to the appropriate department heads routinely. CHR E said percentages of completion and delinquent staff were included in the report. CHR E said employees are assigned training quarterly and it was the employee's responsibility to complete training timely, including Ethics training. She said ultimately the HR department, including herself, was responsible for monitoring employees that were not completing the required training timely and reporting the delinquent staff to the appropriate department heads for appropriate disciplinary actions. CHR E said both the facility HR and department head (director of rehabilitation) responsible facility staff were newly employed or recently appointed to the position and both in training and learning their job responsibilities. CHR E said staff not completing the annual training as required could lead to missed updates and/or poor performance. An attempted interview on 08/12/2026 at 3:15 p.m. with PT F was unsuccessful, no return call to voicemail and text message. During a group interview on 08/12/2026 at 4:15 p.m., 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. He said the facility HR staff was new to her position and was being provided with access and training in the monitoring and reporting of the computer-generated training completion and delinquent staff. He said PT F was a shared employee with another sister facility which was the primary facility for assigning computerized training. He said PT F had not completed his assigned computerized training on ethics and he was unable to provide required training due to assigned training not being completed. He said it was the responsibility of the employees to complete their training on time. He said the department heads were responsible for ensuring staff completed the assigned training and the annual training completion should be monitored closer and delinquent staff should be held accountable. He said he completed random checks on annual trainings completion. He stated not completing annual ethics training as required could lead to employees not receiving updated or changed facility ethics information. A policy addressing annual employee training was requested from the Administrator, CHR E, on 08/12/2026 at 3:00 p.m. but was not provided prior to exit.		

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 08/12/2026
NAME OF PROVIDER OR SUPPLIER Beaumont Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1175 Denton Street 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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interviews and record review, the facility failed to provide required behavioral health training, for 1 of 23 (PT F) staff sampled for licensure and training. The facility failed to ensure that PT F had completed the required behavioral health training. This failure could place residents at risk of being cared for by untrained staff. Review of the facility's training log, undated, showed no evidence of training for behavioral health for PT F. Record review of personnel record for PT F indicated a hire date of 01/31/2025. Review of the facility's training log, undated, showed no evidence of behavioral health training for PT F. Record review of the training log for the previous 12 months (08/12/2025 to 08/12/2026) provided by human resources department indicated no evidence that PT F completed behavioral health training. During an interview on 08/12/2026 at 1:42 p.m., HR D stated she was newly appointed to the facility HR position and was currently being training on her job duties, which will include reviewing and reporting annual training but currently did not have access to view or run reports regarding annual training completion in the computerized training system. Said PT F was a shared employee with another sister facility and was currently on vacation out of the country. During an interview on 08/12/2026 at 1:48 p.m., CHR E said annual required training was computer generated quarterly and staff were provided emails regarding required completion and/or the delinquent courses. CHR E said the annual training completion was reported to the appropriate department heads routinely. CHR E said percentages of completion and delinquent staff were included in the report. CHR E said employees are assigned training quarterly and it was the employee's responsibility to complete training timely, including behavioral health. She said ultimately the HR department, including herself, was responsible for monitoring employees that were not completing the required training timely and reporting the delinquent staff to the appropriate department heads for appropriate disciplinary actions. CHR E said both the facility HR and department head (director of rehabilitation) responsible facility staff were newly employed or recently appointed to the position and both in training and learning their job responsibilities. CHR E said staff not completing the annual training as required could lead to missed updates and/or poor performance. An attempted interview on 08/12/2026 at 3:15 p.m. with PT F was unsuccessful, no return call to voicemail and text message. During a group interview on 08/12/2026 at 4:15 p.m., 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. He said the facility HR staff was new to her position and was being provided with access and training in the monitoring and reporting of the computer-generated training completion and delinquent staff. He said PT F was a shared employee with another sister facility which was the primary facility for assigning computerized training. He said PT F had not completed his assigned computerized training on behavioral health care and services and he was unable to provide required training due to assigned training not being completed. He said it was the responsibility of the employees to complete their training on time. He said the department heads were responsible for ensuring staff completed the assigned training and the annual training completion should be monitored closer and delinquent staff should be held accountable. He said he completed random checks on annual trainings completion. He stated not completing annual behavioral health training as required could lead to employees not receiving updated or changed behavioral health information. A policy addressing annual employee training was requested from the Administrator, CHR E, on 08/12/2026 at 3:00 p.m. but was not provided prior to exit.		