

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2025
NAME OF PROVIDER OR SUPPLIER Jefferson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3840 Pointe Parkway Beaumont, TX 77706	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse and neglect for 9 of 22 residents (Resident #2, Resident #3, Resident #4, Resident #9, Resident #13, Resident #19, Resident #20, Resident #25, and Resident #26) reviewed for abuse.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #3 was free from physical abuse when Resident #2 and Resident #3 had a physical altercation on 10/23/2024. The facility failed to ensure Resident #3 was free from physical abuse when Resident #4 and Resident #3 was in a physical altercation and Resident #4 sustained injuries on 11/09/2024. The facility failed to ensure Resident #4 was free from abuse when Resident #2 wandered into Resident #4's room and both were found on the floor on 11/11/2024. The facility failed to ensure Resident #2 was free from abuse when Resident #3 pushed Resident #2 out of his room causing both residents to fall on 11/23/2024. The facility failed to ensure Residents #25 and #26 were free from abuse when Resident #4 hit Resident #25 and Resident #26 on 04/27/2025. The facility failed to ensure Resident #9 was free from abuse when Resident #5 hit Resident #9 on 01/09/2025. <p>The facility failed to ensure Resident #9 was free from abuse when Resident #5 hit Resident #9 on 02/06/2025.</p> <p>The facility failed to ensure Resident #9 was free from abuse when Resident #5 hit Resident #9 on 02/16/2025.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #13 was free from abuse when Resident #12 hit Resident #13 on 02/15/2025. The facility failed to ensure Resident #20 was free from abuse when Resident #19 touched Resident #20's breast and returned 15 minutes later lifted Resident #20's lap blanket, and placed his hand under blanket near private area on 03/12/2025. <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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An Immediate Jeopardy (IJ) was identified on 05/15/2025 at 3:30 p.m. The IJ template was provided to the facility on [DATE] at 3:45 p.m. While the IJ was removed on 05/17/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>These failures could place residents at risk for emotional distress, fear, decreased quality of life and further abuse.</p> <p>Findings included:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet, dated 04/30/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included dementia (loss of cognitive functioning), bradycardia (slow heart rate), conversion disorder with seizures or convulsions (mental health condition in which individuals experience neurological symptoms without any detectable neurological or medical cause), difficulty walking, unsteadiness on feet, schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges) and hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>Record review of Resident #2's admission MDS Assessment, dated 10/10/2024, indicated he was usually able to make himself understood and sometimes understood others. He had severe cognitive impairment, identified with a BIMS score of 2. He had wandering behaviors that occurred 1 to 3 days within the 7 days look back period and the wandering behaviors significantly intruded on the privacy or activities of others.</p> <p>Record review of Resident #2's care plan dated 10/02/2024 indicated Resident #2 had a behavior problem. Interventions included to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, monitor behavior episodes, and attempt to determine underlying cause, consider location, time of day, persons involved, situations and document behavior and potential causes.</p> <p>Resident #3</p> <p>Record review of Resident #3's face sheet, dated 04/29/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included ulcerative colitis (chronic inflammatory bowel disease that causes ulcers and inflammation in the lining of the colon and rectum), hyperlipidemia (abnormally high levels of fats (lipids) in the blood), colostomy status, chronic kidney disease (a disease or condition impairs kidney function, causing kidney damage), metabolic encephalopathy (a change in how your brain works due to an underlying condition), and hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>Record review of Resident #3's quarterly MDS Assessment, dated 10/01/2024, indicated he was able to make himself understood and usually understood others. He had severe cognitive impairment, identified with a BIMS score of 5. He had behavioral symptoms not directed toward others, rejection of care and wandering behaviors that occurred 1 to 3 days within the 7 days look back period.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's care plan dated 07/28/2022 indicated Resident #3 had a behavior problem. Interventions included to anticipate and meet resident's needs, administer medications as order and document side effects and effectiveness, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, situations and document behavior and potential causes.</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet, dated 05/01/2025, indicated a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included dementia (loss of cognitive functioning), muscle wasting and atrophy, abnormalities of gait and mobility, muscle weakness, difficulty walking, hyperlipidemia (abnormally high levels of fats (lipids) in the blood), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>Record review of Resident #4's admission MDS Assessment, dated 10/21/2024, indicated he was able to make himself understood and usually understood others. He had severe cognitive impairment, identified with a BIMS score of 7. He had verbal behavioral symptoms directed towards others, other behavioral symptoms not directed toward others, and wandering behaviors that significantly intrude on the privacy or activities of others occurred 1 to 3 days within the 7 days look back period.</p> <p>Record review of Resident #4's care plan dated 10/11/2024 indicated Resident #4 was a wanderer. Interventions included to Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, and provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.</p> <p>1. Resident #2 and Resident #3</p> <p>Record review of Resident #2's Resident-to-Resident incident report, dated 10/23/2024, indicated Resident #2 was found lying on Resident #3's floor between the bed and air conditioning unit appears to have been in altercation with Resident #3. Resident #2 assessed with injuries of abrasions to face observed at the time of incident. Resident #3 assessed with injuries of skin tear to left hand and face observed at the time of incident. No pain indicated. Resident #2 and Resident #3 separated and placed on 1:1 monitoring.</p> <p>Record review of a statement dated 10/23/2024 written by LVN D stated she was assessing another resident that had an incident when CNA E hollered help, they are fighting. LVN D entered Resident #3's room and Resident #2 and Resident #3 were observed on the floor between the bed and air conditioning unit having a physical altercation. Staff separated the residents. Resident #2 was removed from the area and the DON, wound care nurse and LVN D assessed both residents for injuries. Both residents were placed on 1:1 monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3 progress note dated 10/23/2024 at 9:29 a.m. authored by LVN D indicated she was summoned to Resident #3's room by CNA E, Resident #3, and Resident #2 fighting over clothing. Residents separated and assessed for injuries and both Resident #2 and Resident #3 placed on 1:1 monitoring. Resident #3 denied pain or discomfort. Resident #3 said altercation occurred due to Resident #2 digging into his personal belongings.</p> <p>Record review of Resident #2's skin and wound assessment dated [DATE], indicated Resident #2 had 2 new wounds, an abrasion to his neck and an abrasion to his right cheek.</p> <p>Record review of Resident #3's skin and wound assessment dated [DATE], indicated Resident #3 had 2 new wounds, skin tear to left dorsum hand and skin tear to cheek.</p> <p>Record review of the facility's Provider Investigation Report, dated 10/30/2024, incident category as other and other specified as a resident-to-resident incident signed by the Administrator on 10/30/2024. PIR indicated the incident occurred 10/23/2024 at 9:30 a.m. on the secure unit. PIR indicated Resident #2 and Resident #3 had a resident-to-resident incident, both on the secure unit with low BIMS scores. Resident #2 wandered into Resident #3's room and proceeded to rummage in his closet and take clothing. Resident #3 attempted to take clothing back from Resident #2 which promoted a tussle between the residents. CNA E heard Resident #3 yell, get the fuck out of my room. CNA E arrived at the room and observed both residents on the floor tussling over clothes. CNA E alerted the CN for assistance, and they were separated immediately with minor skin tears. Wound care nurse and LVN D provided head to toe assessment to Resident #2 and Resident #3 on 10/23/2024 indicating Resident #2 had abrasion to his right cheek and front of his neck, which has resolved, and Resident #3 had a skin tear to his left cheek and left hand and a bruise above his right eye, skin tears were cleansed and treated. Neuro checks were initiated on both residents due to potential fall as both residents were observed on the floor during the resident-to-resident incident. The social worker assessed both residents. Resident #2 had no recollection of the event, and he did not demonstrate any psychosocial concerns currently. Resident #3 was able to discuss the incident but did not want to go into details, but he was in a neutral mood with no signs of agitation or aggression. Reeducated staff on abuse and neglect, resident rights, and care for residents with behaviors, dementia reeducation scheduled for 11/13/2024 with all staff, social worker conducted psychosocial evaluation with no concerns, social worker conducted resident abuse/neglect interviews with no concerns and IDT team met and discussed incident and updated care plans. Conclusion: Confirmed as incident was witnessed. Residents did have a person-to-person interaction with minor skin tears noted and no significant injuries. Resident #2 was a new resident adjusting to his environment. He was assessed by psych services, and they will continue to follow his progress and the medication changes made for Resident #2 was effective.</p> <p>During an interview on 5/14/2025 at 4:45 p.m., CNA E said she heard Resident #3 holler Get the fuck out of my room and she immediately ran down the hall and entered Resident #3's room. She said she saw Resident #2 and Resident #3 on the floor between the bed and the air conditioning unit having an altercation. She hollered for help. She said she and facility staff separated the two Residents and both residents were placed on 1:1 monitoring. She said after the altercation she recalled having to 1:1 monitor Resident #3. She said Resident #3 was upset because Resident #2 was in his room taking his clothes, so they got in a fight. CNA E said she did not see Resident #2 enter Resident #3's room because she was distracted helping the CN and other unit CNA assist a resident that had fallen and was bleeding. CNA E said that Resident #2 was new to the secure unit and a known wanderer, and he should have been monitored to prevent him from wandering into other resident's rooms. CNA E said she had received training regarding redirecting wandering resident from entering other resident's rooms.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An attempted telephone interview on 04/29/2025 at 11:10 a.m. with LVN D, the LVN that witnessed the incident, was unsuccessful.</p> <p>During an interview on 04/29/2025 at 2:00 p.m., Resident #3 said Resident #2 came in his room and was taking his clothes. He said he asked Resident #2 to leave but he did not, so they got into an altercation (he hit Resident #2 with his close fist and was hit by Resident #2's closed fist). He said he received scratches and a black eye from the incident.</p> <p>During an interview on 04/29/2025 at 2:20 p.m., Resident #2 stated I don't recall that at all when asked about the incident between him and Resident #3.</p> <p>2. Resident #3 and Resident #4</p> <p>Record review of Resident #3's care plan, effective on 10/23/2024 (post resident-to-resident incident with Resident #2), indicated the resident had behavior problems of agitated behaviors related to wandering residents entering his room. The interventions included separation of residents, 1:1 monitoring, emergency psych visits by psych services. Resident was taken off 1:1, psych services stated resident is not a risk for another altercation, nurses to continue to monitor and document if any behaviors occur.</p> <p>Record review of Resident #3's Resident-to-Resident incident report, dated 11/09/2024, LVN C was summoned by CNA F to Resident #3's room, Resident #3 and Resident #4 were fighting. The nurse entered the room and observed Resident #3 holding another resident (Resident #4) against the wall hitting the other resident several times in the face, appears to be having altercation with another resident. The nurse separated residents. Head to toe assessment initiated, resident denies pain at this time, no injuries noted at this time. Neuro checks initiated. DON, RP, NP, and local police department notified. Resident #3 states he came into my room saying this was his room and my clothes was his clothes. I tried to tell him to leave but he kept taking my stuff. Resident #3 assessed with no injuries observed at the time of incident. Pain level indicated 2. Resident #4 and Resident #3 separated, and Resident #4 placed on 1:1 monitoring.</p> <p>Record review of Resident #4 progress note dated 11/09/2024 at 2:35 p.m. authored by LVN C indicated she was summoned to Resident #3's room by CNA F, Resident #3, and Resident #4 were fighting. Upon entering the room Resident #3 had Resident #4 pinned against the wall, hitting him in the face. LVN C separated residents and assessed for injuries. Resident #4 had scratch to left eyelid with bleeding noted, and bump to left cheek with redness and swelling, treatment provided. Resident #4 denied pain. Resident #4 was placed on 1:1 monitoring. Neuro checks initiated on Resident #4.</p> <p>Record review of Resident #3's skin and wound assessment dated [DATE], indicated Resident #3 had no new wounds.</p> <p>Record review of Resident #4's skin and wound assessment dated [DATE], indicated Resident #4 had two new wounds scratch to left eyelid and bump to his left cheek.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's Resident-to-Resident incident report, dated 11/09/2024, LVN C was summoned by CNA F to Resident #3's room, Resident #3 and Resident #4 were fighting. The nurse entered the room and observed Resident #3 Resident #4 against the wall hitting him several times in the face. The nurse and CNA separated residents. Head to toe assessment initiated, resident denies pain at this time. Resident #4 had a bleeding scratch to left eye lid and red, swollen bump to left cheek observed at time of incident. Resident #4 placed on 1:1 and neuro checks initiated. DON, RP, NP, and local police department notified. Resident #4 stated he was in my room.</p> <p>Record review of the facility's Provider Investigation Report, dated 11/15/2024, incident category as other and other specified as a resident-to-resident incident signed by the DON on 11/15/2024. PIR indicated the incident occurred 11/09/2024 at 2:30 a.m. on the secure unit. PIR indicated CNA F heard Resident #3 yell get the fuck out of my room. She went to assess and observed Resident #3 and Resident #4 tussling in Resident #3's room. CNA F stated that Resident #3 hit Resident #4. CNA F alerted the CN for assistance, and they were separated immediately. Resident #3 had no injuries and Resident #4 had redness and discoloration noted under his left eye and a scratch to his left eyebrow; no hospitalization or further medical treatment was required. Neuro checks were initiated on both residents. The social worker assessed both residents. Post incident interventions included residents on hall were assessed with no concerns noted, staff interviews with no concerns noted, reeducated staff on abuse and neglect, resident rights and care for residents with behaviors, dementia reeducation scheduled for 11/13/2024 with all staff, social worker conducted psychosocial evaluation with no concerns, social worker conducted resident abuse/neglect interviews with no concerns and IDT team met and discussed incident and updated care plans. Resident #4 had medication changes and after continued display of aggressive behaviors was evaluated and admitted to a behavioral hospital on [DATE]. Conclusion: Confirmed that residents did have a person-to-person interaction with no major injury however with a low BIMS these residents were reactive to situation and not intentional to hurt others.</p> <p>During an interview on 04/29/2025 at 2:10 p.m., Resident #3 said Resident #4 came in his room during the night or early morning and demanded Resident #3 to get out of his bed/room and would not leave. He said he defended himself from Resident #4 and he hit Resident #4 trying to get him out of his room.</p> <p>During an interview on 04/29/2025 at 2:45 p.m., Resident #4 stated he does not recall being in an altercation.</p> <p>During an interview on 05/01/2025 at 9:32 a.m., CNA F said she heard Resident #3 holler get the fuck out of my room in the early morning hours of 11/09/2024 so she ran to Resident #3's room and found Resident #3 and Resident #4 shoving each other around and witnessed Resident #4 hit Resident #3 in the face with his hand. CNA F said she separated the residents and redirected Resident #4 back to his room; she said Resident #4 was hard to redirect at times. CNA F said she was the only staff on the secure unit because the other CNA was on break. CNA F said she notified the CN by opening the keypad secure unit doors and hollering for the nurse. CNA F said CN assessed both residents and Resident #4 was placed on 1:1 monitoring. CNA F said that Resident #4 went into Resident #3's room, telling him to get out of his bed/house. CNA F said Resident #4 was a wanderer and had aggressive behaviors at times and Resident #3 did not get aggressive until someone entered his room uninvited and messed with his belongings. NA F said she had received training regarding redirecting wandering resident from entering other resident's rooms prior to incident. CNA F said while she was in Resident #3's room separating the residents and redirecting Resident #4 there was a short timespan that no one was supervising the other residents because she was in the resident's room and not watching the hall.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/05/2025 at 11:07 a.m., LVN C said she was notified by CNA F that Resident #3 and Resident #4 were fighting. She said upon entering the unit, CNA F had already separated the residents. She said Resident #3 said Resident #4 came in his room and was telling him to get out of his bedroom. She said Resident #3 said he told Resident #4 he was in the wrong room, but he got upset. She said Resident #3 said he did defend himself and hit Resident #4. She said she assessed both residents but does not recall what injuries were obtained but she would have documented the injuries and pain in the resident's medical records. She said Resident #4 was placed on 1:1 monitoring.</p> <p>3. Resident #2 and Resident #4</p> <p>Record review of Resident #2's care plan, effective on 10/23/2024 (post resident-to-resident altercation with Resident #3), indicated the resident had a resident-to-resident altercation related to dementia/wandering into another resident's room and rummaging through closets. The interventions included emergency psych visits per psych care, increase dosage olanzapine, monitor for agitated behaviors or triggers, and attempt to intervene before an incident occurs, monitor resident while ambulating in the hallways and redirect resident as needed if attempting to enter other residence rooms, and reeducate staff on abuse neglect resident to resident abuse and resident rights.</p> <p>Record review of Resident #4's care plan, effective on 11/09/2024 (post resident-to-resident altercation with Resident #3), indicated the resident had potential to be physically aggressive related to dementia and wandering behaviors with actual aggressive behavior noted due to wandering in another resident's room. The interventions included resident to resident altercation, 1:1 monitoring, administer medications as ordered, assess resident's needs, provide physical and verbal cues to alleviate anxiety, monitor/document/report prn any signs or symptoms of resident posing danger to self or others, when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later and psychiatric/psychogeriatric consult as indicated.</p> <p>Record review of Resident #4 progress note authored by LVN D dated 11/11/2024 at 6:00 a.m., Resident was taken off 1:1 supervision from incident on 11/09/2024. Neuros remain in progress as well as close monitoring. Will continue to monitor.</p> <p>Record review of a Resident-to-Resident incident report, dated 11/11/2024, LVN JJ was informed by CNA V that Resident #4 was on the floor and Resident #2 was on top of him, and they were in a tussling due to Resident #2 entering Resident #4's room. Resident #4 stated, I'm tired of people coming in my room. Residents separated immediately, head to toe assessment initiated, resident denies pain at this time, no injuries noted at this time. Neuro checks initiated. DON, RP, NP, and local police department notified.</p> <p>Record review of Resident #2 progress note dated 11/11/2024 at 6:50 p.m. authored by LVN JJ indicated she was informed that Resident #2 and Resident #4 was on the floor in Resident #4's room tussling due to Resident #2 had entered Resident #4's room without asking. Residents were separated immediately, Resident #2 was a wanderer, assessment completed, no apparent injuries noted.</p> <p>Record review of Resident #2's skin and wound assessment dated [DATE], indicated Resident #2 had no new wounds.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4 progress note dated 11/11/2024 at 6:54 p.m. authored by LVN JJ indicated she was informed that Resident #4 and Resident #2 was on the floor in Resident #4's room tussling due to Resident #2 entered Resident #4's room without asking. Resident #4 stated I'm tired of people coming in my room. Resident #4 was assessed, no apparent injuries noted. Resident #4 placed on 1:1 monitoring to avoid any aggression to other residents.</p> <p>Record review of Resident #4's skin and wound assessment dated [DATE], indicated Resident #4 had no new wounds.</p> <p>Record review of the facility's Provider Investigation Report, dated 11/18/2024, incident category as other and other specified as a resident-to-resident incident signed by the DON on 11/18/2024. PIR indicated the incident occurred 11/11/2024 at 6:50 p.m. on the secure unit. PIR indicated Resident #2 wandered into Resident #4's room. CNA V heard Resident #4 yell it's you again get out. CNA ran to the Resident #4's room and observed Resident #4 on top of Resident #2 attempting to hit him. CNA V separated the two residents and notified the CN. CN performed head to toe assessment on both residents with no injuries observed and both denied pain. Resident #4 was placed on 1:1 supervision. The MD was contacted and gave orders for Resident #4 to have inpatient behavioral referral. Psych services contacted and performed an evaluation with medication changes. Reeducated staff on abuse and neglect, resident rights, and care for residents with behaviors, dementia reeducation scheduled for 11/13/2024 with all staff, social worker conducted psychosocial evaluation with no concerns, social worker conducted resident abuse/neglect interviews with no concerns and IDT team met and discussed incident and updated care plans. Resident #4 had medication changes and after continued display of aggressive behaviors was evaluated and admitted to a behavioral hospital on [DATE]. Conclusion: Confirmed that residents did have a person-to-person interaction with no major injury however with a low BIMS these residents were reactive to situation and not intentional to hurt others.</p> <p>An attempted telephone interview on 05/13/2025 at 1:10 p.m. with LVN JJ, was unsuccessful.</p> <p>During an interview on 05/13/2025 at 2:25 p.m., Resident #2 stated I don't recall that when asked about the incident between him and Resident #4.</p> <p>During an interview on 05/13/2025 at 2:55 p.m., Resident #4 stated he does not recall being in an altercation, but I do not like people in his room/house.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Jefferson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3840 Pointe Parkway Beaumont, TX 77706	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/14/2025 at 2:00 p.m., CNA V said she was working the secure unit on 11/11/2024, around 6:45 p.m. and as she was in the hallway near the secure unit nurses' station, she recalled seeing Resident #2 standing at the unit entrance double doors (at the opposite end of the hall) looking out the window. CNA V said maybe a minute later she heard it's you again, get out and ran down the hallway to Resident #4's room (first door to the left when entering the unit through the double doors - approx. 91 feet from nurses' station) where she observed Resident #4 on top of Resident #2 trying to hit him. CNA V said she did not witness anyone get hit but they were both on the floor. CNA V said she followed training she had been provided and separated them immediately and she had to open the keypad secure unit doors and hollered for the nurse for assistance due to resident-to-resident altercation. CNA V said she was on the secure unit alone at the time of the incident because the other CNA was on break. NA V said that if staff is leaving the unit that CN and other staff should be notified, should always be one staff on the secure unit to monitor residents. CNA V said she had received training regarding redirecting wandering resident from entering other resident's rooms. She said the CN sat at the nurses' station outside the secure unit after 6:00 p.m. because she had to monitor another hall other than the secure unit.</p> <p>4. Resident #2 and Resident #3</p> <p>Record review of Resident #2's, effective on 10/23/2024, indicated the care plan was not updated post a resident-to-resident altercation on 11/11/2024 involving Resident #4.</p> <p>Record review of Resident #3's care plan, effective on 11/09/2024, indicated the resident had behavior problems of agitated behaviors related to wandering residents entering his room. The interventions included resident to resident altercation, staff to redirect wandering residents from entering Resident #3's room, separation of residents, 1:1 monitoring, emergency psych visits by psych services if applicable.</p> <p>Record review of Resident #2 progress note dated 11/23/2024 at 5:33 p.m. authored by LVN G indicated she was notified by CNA H that Resident #2 was in Resident #3's room taking Resident #3's snacks and Resident #3 confronted Resident #2 and was pushing him out of his room and during the altercation they both fell, landing on their buttocks. Resident #2 and Resident #3 was attempting to hit and kick each other but staff was able to intervene before resident's could make contact. Residents were separated. Resident #2 shrugged his shoulders when asked what happened and continued to eat snack cake, he took from Resident #3's room. Residents separated and assessed for injuries and denied pain and showed no nonverbal indicators of discomfort.</p> <p>Record review of a Resident-to-Resident incident report, dated 11/23/2024, indicated CNA H noted Resident #3 was pushing Resident #2 out of his room and onto the floor. Resident #2 landed on his buttocks. Resident #3 lost his balance and landed on his buttocks while attempting to grab Resident #2 and yelling he's stealing. Once on the floor Resident #2 and Resident #3 continued to attempt to hit and kick one another. Staff able to intervene before resident's could make contact. Resident #2 had a snack cake in his hand and once assist off floor walked off eating cake. Resident #3 stated Resident #2 came into his room and took his snacks and started eating them. Resident #3 assessed with no injuries observed at the time of incident. No pain indicated. Resident #3 was placed on 1:1 monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3 progress note dated 11/23/2024 at 5:01 p.m. authored by LVN G indicated CNA H notified her that Resident #3 was pushing Resident #2 out of his room and during the altercation they both fell, landing on their buttocks. Resident #3 was yelling he's stealing. Resident #2 and Resident #3 were attempting to hit and kick each other but staff was able to intervene before resident's could make contact. Residents were separated. Resident #3 said Resident #2 came in his room and started eating his snacks. Residents separated and assessed for injuries and denied pain and showed no nonverbal indicators of discomfort. LVN G received new lab orders for Resident #3 and to start Depakote 250 mg twice a day to help with agitation and mood stabilization.</p> <p>Record review of Resident #3's skin and wound assessment dated [DATE], indicated Resident #3 had no new wounds.</p> <p>Record review of the facility's Provider Investigation Report, dated 11/27/2024, incident category as other and other specified as a resident-to-resident incident signed by the DON on 11/27/2024. PIR indicated the incident occurred 11/23/2024 at 2:40 p.m. on the secure unit. PIR indicated Resident #3, and Resident #4 had a resident-to-resident incident, both resided on the secure unit with low BIMS and wandering behaviors. Resident #2 wandered into Resident #3's room and proceeded to rummage in his Resident #3 bedside table snacks. Resident #3 attempted to get Resident #2 out of his room by pushing him out and both residents fell. CNA H was walking down the hall when she observed Resident #3 pushing Resident #2 out of his room into the hallway causing both residents to fall to the ground. Staff reported neither resident hit their head but landed on their buttocks. Staff separated the two residents immediately. CN assessed both residents and no injuries identified. Resident #3 was placed on 1:1 monitoring. Resident #3 said Resident #2 was taking his snacks from his room. Resident #2 had a snack in his hand during the incident. Resident #3 was placed on Depakote 250 mg twice a day related to aggressive reaction to patient wandering into room. Resident #3 was evaluated and treated for a UTI following the incident. Reeducated staff on abuse and neglect, resident rights, and care for residents with behaviors, social worker conducted resident abuse/neglect interviews with no concerns and IDT team met and discussed incident and updated care plans. Conclusion: Confirmed as[TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement the written abuse policy to ensure an allegation of physical abuse was reported immediately to the Abuse Coordinator, State Agency, and implement measures to ensure residents were protected from further abuse after an allegation of abuse for 1 of 22 residents (Resident #1) reviewed for allegations of abuse.</p> <p>1. The facility failed to ensure CNA B was suspended/ terminated or removed from all residents after a physical abuse allegation was reported on 03/11/2025.</p> <p>2. The facility failed to immediately report the physical abuse allegation to the Abuse Coordinator for Resident #1.</p> <p>The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 03/11/2025 and ended on 03/17/2025. The facility had corrected the non-compliance before the survey began.</p> <p>This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>Record review of the facility's policy Abuse Prohibition Protocol, dated 08/15/2022, indicated It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, b. Establish policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and d. Establish coordination with the QAPI program. 2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the face sheet dated 05/01/2025 indicated Resident #1 was admitted on [DATE], she was [AGE] years old with diagnoses of vascular dementia (a type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain) with anxiety (feelings of worry or fear), Delirium (serious disturbances in mental abilities that results in confusion) and altered mental status. Resident #1 had a readmission date of 04/22/2025.</p> <p>Record review of admission MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 00 indicated she had severely impaired cognition. She was usually able to make herself understood and understood others. Resident #1 had behaviors of verbal behavioral symptoms directed toward others and behavioral symptoms not directed toward others (wandering and rummaging) 1 to 3 times weekly.</p> <p>Record review of Resident #1's care plan, dated 04/22/2025, indicated she had a potential to be physically aggressive related to dementia, poor impulse control and she refused medications. Resident #1 was verbally aggressive towards staff and other residents related to dementia, ineffective coping skills, and poor impulse control.</p> <p>During an observation and interview on 04/29/2025 at 10:00 a.m., Resident #1 was in her bed in the secure unit. She was awake however she would not answer questions then she yelled get out.</p> <p>Record review of a nurse note dated 03/12/2025 at 7:00 a.m., the DON indicated an allegation of abuse was reported at 7:00 a.m., on 03/12/2025 via statement under the DON door. CNA A documented in her statement that CNA B was escorting resident down the hallway by her arm and sat her down in the chair roughly. LVN C went immediately attempted to complete a head-to-toe assessment. Resident refused and would not allow this nurse to assess her. Resident told this nurse to get out of room. Resident was unable to properly be interviewed due to her inability to make sentences. Resident has a diagnosis of vascular dementia and has a history of refusing care. LVN C asked resident if she was in any pain. Resident denied pain and no facial grimacing noted.</p> <p>During an interview 04/30/2025 at 1:45 p.m., CNA A said on 03/11/2025 at approximately 11:30 p.m., she witnessed CNA B physically abuse Resident #1 while CNA B was assisting Resident #1. CNA A said she watched through the window on the door to the secure unit as CNA B and Resident #1 were walking towards Resident#1's room. Resident #1 grabbed hold of the rail on the wall and CNA B roughly pulled her arms and hands off the rail. She said CNA B walked with Resident #1 then grabbed the resident by the upper arms and pushed her into a chair in her doorway. CNA A said she could not hear what was being said. CNA A said at that point she entered the secure unit and stated, I told her (CNA B) to stop treating Resident #1 like that. CNA A said CNA B said it did not matter because Resident #1 was being transferred to the behavior hospital soon for her behaviors. CNA A said LVN C walked into the unit and talked to us separately. CNA A said she and CNA B worked the rest of the shift. CNA A said at the end of the shift she wanted to talk with the DON or ADONs, but they were not there yet, so she left the note under the DON's door. She said she was suspended during investigation and then transferred to another facility. She said this facility retrained her on reporting to the Abuse Coordinator immediately, and she said the Abuse Coordinator was the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/30/2025 at 8:45 a.m., CNA B said CNA A accused her of being rough with Resident #1 on the night of 03/11/2025. She said she had never mistreated a resident. CNA B said CNA A came on the unit and started accusing her of abuse. CNA B stated, I had to walk with Resident #1 back to her room from the dining area because she was getting all straws and stir sticks for the coffee and dropping them on the floor. She said as we walked the resident lean to the side, and she grabbed Resident #1 by her arms to prevent falling. She said Resident #1 grabbed the rail and she lifted her hands off the rail so they could continue walking. She said then she assisted Resident #1 into a chair. CNA B said, CNA A had been late again or was in her car and was not even on the unit. CNA B said she was suspended the next day. CNA B said after CNA A accused her of abuse, she was allowed to work the rest of the shift then terminated the next day.</p> <p>During an interview on 04/30/2025 at 9:50 a.m. LVN C said on the night of 03/11/2025 around 11:30 p.m., someone yelled out of the secure unit and said the aides (CNA A and CNA B) were arguing. She was not sure who yelled. She said she went into the secure unit. She separated the CNAs and talked with CNA A first. She said CNA A said CNA B was rough with Resident #1 and abused her. CNA B denied the allegation of abuse. She denied reporting to the Abuse Coordinator and said she should have reported the allegation immediately. She said she was terminated for not following the abuse policy on reporting to the Abuse Coordinator which was the Administrator. She said she was trained on hire and monthly since she was hired years ago.</p> <p>Prior to surveyor entrance, the facility took the following actions to correct the failure:</p> <p>Facility initiated assessment and monitoring of Resident #1 following the incident.</p> <p>Facility suspended CNA A, CNA B, and LVN C on 03/12/2025.</p> <p>CNA B was terminated for being named in the abuse allegation and LVN C was terminated for not reporting the physical abuse allegation timely.</p> <p>Staff were In-serviced on physical abuse reporting and allegations and now required to report all allegations to the Abuse Coordinator or the DON.</p> <p>Facility conducted skin assessments for the residents residing on the unit.</p> <p>Multiple interviews indicated staff were knowledgeable on physical abuse policy and interventions to keep residents safe.</p> <p>QAPI/QAA has implemented and is monitoring the interventions in place related to the incident.</p> <p>Record review of CNA B's sign in sheet indicated she was on duty on 03/11/2025 and worked 10:00 p.m. to 6:00 a.m.</p> <p>Record review of CNA A's personnel file indicated she was suspended pending the investigation on 03/12/2025 then she was transferred to another facility. She was retrained on Abuse.</p> <p>Record review of LVN C's personnel file indicated she was terminated for not reporting the physical abuse allegation to the Abuse Coordinator.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of CNA B's employee personnel file indicated she was suspended pending investigation of an allegation of abuse of resident on 3/12/2025 then terminated about being named in an allegation of abuse.</p> <p>Record review of an In-Service Attendance Record with subject of Abuse, Neglect, Exploitation, and timely reporting, dated 03/12/2025, indicated that 47 staff members signed the in-service record, and 76 staff members were notified by phone regarding all allegations of abuse must be reported to the abuse coordinator immediately and Abuse Coordinator's phone number provided to report abuse allegations.</p> <p>Record review of facility reported abuse allegations incidents from 03/12/2025 through 05/05/2025 indicated the resident was protected immediately from more abuse.</p> <p>Record review of skin assessments dated 03/12/2025 for the residents residing on the unit indicated no new wounds, skin tears or bruises were identified.</p> <p>Record Review of Safe Surveys for six residents dated 03/12/2025 indicated there no residents expressing concerns regarding their safety or abusive staff.</p> <p>Record Review of multiple employee Abuse/Neglect and Compliance Questionnaire's dated between 03/12/2025 and 03/17/2025 indicated staff answered questions based on the in-services provided.</p> <p>During interviews on 04/29/2025 at 9:00 a.m. - 05/01/2025 to 3:00 p.m., DON, ADON AAA, ADON BBB, SW and Wound Care nurse were able to identify how to care for residents with aggressive behaviors, types of abuse, all were knowledgeable of the abuse policy and procedures for reporting abuse, and all were aware of the new expectations to notify the Abuse Coordinator immediately of any allegations of abuse.</p> <p>During interviews on 04/29/2025 at 9:00 a.m. - 05/01/2025 to 3:00 p.m., 10 LVNs (LVN C, LVN D, LVN G, LVN J, LVN L, LVN N, LVN O, LVN P, LVN T, and LVN GG) were able to identify how to care for residents with aggressive behaviors, types of abuse, all were knowledgeable of the abuse policy and procedures for reporting abuse, and all were aware of the new expectations to notify the Abuse Coordinator immediately of any allegations of abuse.</p> <p>During interviews on 04/29/2025 at 9:00 a.m. - 05/01/2025 to 3:00 p.m. to 17 CNAs (CNA B, CNA E, CNA F, CNA H, CNA K, CNA M, CNA U, CNA V, CNA W, CNA X, CNA Y, CNA Z, CNA AA, CNA BB, CNA CC, CNA DD, and CNA FF) and 3 MAs (MA Q, MA R, and MA S) were able to identify how to care for residents with aggressive behaviors, types of abuse, all were knowledgeable of the abuse policy and procedure for reporting abuse, all were aware of the new expectations to notify the Abuse Coordinator immediately of any allegations of abuse.</p> <p>During an interview on 05/01/2025 at 2:10 p.m., the Administrator and DON said if the allegation involves staff and was related to abuse the staff should be suspended immediately to prevent to remove the potential for more abuse or harm. They said the retraining was completed on all staff. They said when the staff hears or sees abuse, they were to report immediately per the facility policy. The DON said the staff had our contact information and it was posted in the facility. They said all the staff filled out a questioner about abuse.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 05/01/2025 at 4:53 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 03/11/2025 and ended on 03/17/2025. The facility had corrected the noncompliance before survey began.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 2 of 22 residents (Resident #19 and Resident #20) reviewed for reporting allegations of abuse.</p> <p>The facility failed to report sexual abuse to the State Agency within 2 hours when it was reported to ADON AAA that LVN O witnessed Resident #19 touch Resident #20's breast over her clothes and MA Q witness him return 15 minutes later and lift lap blanket, and place his hand under blanket near private area on 03/12/2025.</p> <p>This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>1. Record review of Resident #19's face sheet dated 04/30/2025 indicated he was an [AGE] year-old male, admitted on [DATE], and his diagnoses included diabetes (high blood sugar levels), dementia and Alzheimer's Disease.</p> <p>Record review of the quarterly MDS assessment dated [DATE] indicated Resident #19 usually makes self-understood and usually understands. He had a BIMS score of 9 which indicated moderate cognitive impairment. No behaviors of sexual abuse were noted.</p> <p>Record review of the care plan dated 09/08/24 indicated Resident #19 had impaired cognitive function or impaired thought processes Alzheimer's Disease / dementia.</p> <p>Record review of Resident #19's nurse notes authored by LVN O indicated on 3/12/2025 at 12:46 p.m. Resident had to be redirected several times away from female resident while sitting in TV room due to being inappropriate and touching a resident's breast. Resident was educated on why his behavior was inappropriate and resident stated ok. Staff noticed resident again doing the same thing a few minutes later and again had to be redirected and educated. Incident was reported to ADON AAA, and administrator was notified.</p> <p>2. Record review of Resident #20's face sheet dated 04/30/2025 indicated she was a [AGE] year-old female, admitted on [DATE], and her diagnoses included alcohol dependence, dementia, irregular heart, and high blood pressure.</p> <p>Record review of the admission MDS assessment dated [DATE] indicated Resident #20 usually makes self-understood and usually understands. She had a BIMS score of 10 which indicated moderate cognitive impairment. No behaviors of sexual abuse were noted.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the care plan dated 02/28/2025 indicated Resident #20 had impaired cognitive function or impaired thought processes related to dementia.</p> <p>Record review of Resident #20's nurse's notes indicated on 03/13/2025 at 12:39 p.m., Facility Social Worker attempted to perform a psychosocial assessment on resident post-incident. Resident unable to participate in assessment due to significant cognitive impairment. Resident in bed showing no signs of distress or agitation. Resident shows signs of restlessness, nurse notified. FSW contacted resident's POA to notify family of the incident. Facility staff observed a male resident having a sexual approach to female resident. Male resident was easily redirected to ensure female residents' safety and he was placed on 1:1 for continuous monitoring. Resident's responsible verbalized understanding and appreciated being notified. No further concerns to be addressed at this time.</p> <p>Record review of the facility's print-out from TULIP dated 03/19/2025 indicated the incident of 03/12/2025 12:46 p.m. and was reported on 03/13/2025 at 12:05 p.m. The incident happened on 03/12/2025 at 12:46 p.m. Resident #19 touched Resident #20 breast while in the sitting area and was observed by LVN O.</p> <p>During an interview on 05/05/2025 at 10:45 a.m., LVN O said on 03/12/2025 after lunch Resident #19 was in the common area and was sitting next to Resident #20. Resident#19's hand was on Resident #20 breast. She said both residents were fully dressed. She said Resident #19's hand was on top of Resident #20 clothed breast and was not moving. She said she removed Resident #19 up by the nurse's station away from Resident #20. She said both residents denied any knowledge of the incident. She said Resident #19 denied touching Resident #20. LVN O said Resident #20 had no recall of anyone touching her breast. She said she charted the Administrator was notified because ADON AAA went to the conference room after hearing about the incident. She said later she was told ADON AAA had not reported the incident to the Abuse Coordinator.</p> <p>During an interview on 05/05/2025 at 11:08 a.m., MA Q said on 03/12/2025 around 1:00 p.m., Resident #19 was reaching under a blanket on Resident #20 as they were in the common area. She said under the waist area but only the hand was under the cover. She said she could not see what he was touching but did not to appear under the blanket for enough to touch private areas. She said brought him to the nurse's station and reported to LVN O and 1 on 1 was initiated.</p> <p>During an interview on 05/05/2025 at 3:00 p.m., the DON said he expected allegations of any type of abuse to be reported immediately. He said this was an allegation of resident-to-resident sexual abuse. He said they restrained the ADON and all the staff.</p> <p>During an interview on 05/05/2025 at 3:31 p.m., the Administrator said her expectations for all allegations of abuse to be reported to her immediately. She said the allegations of abuse be should reported within 2 hours to the State Agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Abuse, Neglect and Exploitation Policy dated 08/15/2022 indicated It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property . Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 9 of 22 residents (Resident #2, Resident #3, Resident #4, Resident #9, Resident #13, Resident #19, Resident #20, Resident #25, and Resident #26) reviewed for supervision to prevent accidents.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #3 was free from physical abuse when Resident #2 and Resident #3 had a physical altercation on 10/23/2024. The facility failed to ensure Resident #3 was free from physical abuse when Resident #4 and Resident #3 was in a physical altercation and Resident #4 sustained injuries on 11/09/2024. The facility failed to ensure Resident #4 was free from abuse when Resident #2 wandered into Resident #4's room and both were found on the floor on 11/11/2024. The facility failed to ensure Resident #2 was free from abuse when Resident #3 pushed Resident #2 out of his room causing both residents to fall on 11/23/2024. The facility failed to ensure Residents #25 and #26 were free from abuse when Resident #4 hit Resident #25 and Resident #26 on 4/27/2025. The facility failed to ensure Resident #9 was free from abuse when Resident #5 hit Resident #9 on 01/09/2025. <p>The facility failed to ensure Resident #9 was free from abuse when Resident #5 hit Resident #9 on 02/06/2025.</p> <p>The facility failed to ensure Resident #9 was free from abuse when Resident #5 hit Resident #9 on 02/16/2025.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #13 was free from abuse when Resident #12 hit Resident #13 on 02/15/2025. The facility failed to ensure Resident #20 was free from abuse when Resident #19 touched Resident #20's breast and returned 15 minutes later lifted Resident #20's lap blanket, and placed his hand under blanket near private area on 03/12/2025. <p>The facility did not review, update, or implement interventions to include adequate supervision and continued to allow Resident #2 and Resident #4 to wander unsupervised in secure unit with potential for them and other residents to be abused.</p> <p>The facility did not review, update, or implement interventions to include adequate supervision and continued to allow Resident #2 and Resident #4 to wander into Resident #3's room with potential for them and other residents to be abused.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility did not review, update, or implement interventions to include adequate supervision and continued to leave Resident #5 alone and unsupervised with Resident #9 and other residents.</p> <p>The facility did not review, update, or implement interventions to include adequate supervision and allowed Resident #19 touch Resident #20's breast and return 15 minutes later and lift lap blanket, and place his hand under blanket near private area.</p> <p>An Immediate Jeopardy (IJ) was identified on 05/15/2025 at 3:30 p.m. The IJ template was provided to the facility on [DATE] at 3:45 p.m. While the IJ was removed on 05/17/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>These failures could place residents at risk for emotional distress, fear, decreased quality of life and further abuse.</p> <p>Findings included:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet, dated 04/30/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included dementia (loss of cognitive functioning), bradycardia (slow heart rate), conversion disorder with seizures or convulsions (mental health condition in which individuals experience neurological symptoms without any detectable neurological or medical cause), difficulty walking, unsteadiness on feet, schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges) and hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>Record review of Resident #2's admission MDS Assessment, dated 10/10/2024, indicated he was usually able to make himself understood and sometimes understood others. He had severe cognitive impairment, identified with a BIMS score of 2. He had wandering behaviors that occurred 1 to 3 days within the 7 days look back period and the wandering behaviors significantly intruded on the privacy or activities of others.</p> <p>Record review of Resident #2's care plan dated 10/02/2024 indicated Resident #2 had a behavior problem. Interventions included to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, monitor behavior episodes, and attempt to determine underlying cause, consider location, time of day, persons involved, situations and document behavior and potential causes.</p> <p>Resident #3</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's face sheet, dated 04/29/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included ulcerative colitis (chronic inflammatory bowel disease that causes ulcers and inflammation in the lining of the colon and rectum), hyperlipidemia (abnormally high levels of fats (lipids) in the blood), colostomy status, chronic kidney disease (a disease or condition impairs kidney function, causing kidney damage), metabolic encephalopathy (a change in how your brain works due to an underlying condition), and hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>Record review of Resident #3's quarterly MDS Assessment, dated 10/01/2024, indicated he was able to make himself understood and usually understood others. He had severe cognitive impairment, identified with a BIMS score of 5. He had behavioral symptoms not directed toward others, rejection of care and wandering behaviors that occurred 1 to 3 days within the 7 days look back period.</p> <p>Record review of Resident #3's care plan dated 07/28/2022 indicated Resident #3 had a behavior problem. Interventions included to anticipate and meet resident's needs, administer medications as order and document side effects and effectiveness, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, situations and document behavior and potential causes.</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet, dated 05/01/2025, indicated a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included dementia (loss of cognitive functioning), muscle wasting and atrophy, abnormalities of gait and mobility, muscle weakness, difficulty walking, hyperlipidemia (abnormally high levels of fats (lipids) in the blood), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>Record review of Resident #4's admission MDS Assessment, dated 10/21/2024, indicated he was able to make himself understood and usually understood others. He had severe cognitive impairment, identified with a BIMS score of 7. He had verbal behavioral symptoms directed towards others, other behavioral symptoms not directed toward others, and wandering behaviors that significantly intrude on the privacy or activities of others occurred 1 to 3 days within the 7 days look back period.</p> <p>Record review of Resident #4's care plan dated 10/11/2024 indicated Resident #4 was a wanderer. Interventions included to Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, and provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.</p> <p>1. Resident #2 and Resident #3</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's Resident-to-Resident incident report, dated 10/23/2024, indicated Resident #2 was found lying on Resident #3's floor between the bed and air conditioning unit appears to have been in altercation with Resident #3. Resident #2 assessed with injuries of abrasions to face observed at the time of incident. Resident #3 assessed with injuries of skin tear to left hand and face observed at the time of incident. No pain indicated. Resident #2 and Resident #3 separated and placed on 1:1 monitoring.</p> <p>Record review of a statement dated 10/23/2024 written by LVN D stated she was assessing another resident that had an incident when CNA E hollered help, they are fighting. LVN D entered Resident #3's room and Resident #2 and Resident #3 were observed on the floor between the bed and air conditioning unit having a physical altercation. Staff separated the residents. Resident #2 was removed from the area and the DON, wound care nurse and LVN D assessed both residents for injuries. Both residents were placed on 1:1 monitoring.</p> <p>Record review of Resident #3 progress note dated 10/23/2024 at 9:29 a.m. authored by LVN D indicated she was summoned to Resident #3's room by CNA E, Resident #3, and Resident #2 fighting over clothing. Residents separated and assessed for injuries and both Resident #2 and Resident #3 placed on 1:1 monitoring. Resident #3 denied pain or discomfort. Resident #3 said altercation occurred due to Resident #2 digging into his personal belongings.</p> <p>Record review of Resident #2's skin and wound assessment dated [DATE], indicated Resident #2 had 2 new wounds, an abrasion to his neck and an abrasion to his right cheek.</p> <p>Record review of Resident #3's skin and wound assessment dated [DATE], indicated Resident #3 had 2 new wounds, skin tear to left dorsum hand and skin tear to cheek.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Provider Investigation Report, dated 10/30/2024, incident category as other and other specified as a resident-to-resident incident signed by the Administrator on 10/30/2024. PIR indicated the incident occurred 10/23/2024 at 9:30 a.m. on the secure unit. PIR indicated Resident #2 and Resident #3 had a resident-to-resident incident, both on the secure unit with low BIMS scores. Resident #2 wandered into Resident #3's room and proceeded to rummage in his closet and take clothing. Resident #3 attempted to take clothing back from Resident #2 which promoted a tussle between the residents. CNA E heard Resident #3 yell, get the fuck out of my room. CNA E arrived at the room and observed both residents on the floor tussling over clothes. CNA E alerted the CN for assistance, and they were separated immediately with minor skin tears. Wound care nurse and LVN D provided head to toe assessment to Resident #2 and Resident #3 on 10/23/2024 indicating Resident #2 had abrasion to his right cheek and front of his neck, which has resolved, and Resident #3 had a skin tear to his left cheek and left hand and a bruise above his right eye, skin tears were cleansed and treated. Neuro checks were initiated on both residents due to potential fall as both residents were observed on the floor during the resident-to-resident incident. The social worker assessed both residents. Resident #2 had no recollection of the event, and he did not demonstrate any psychosocial concerns currently. Resident #3 was able to discuss the incident but did not want to go into details, but he was in a neutral mood with no signs of agitation or aggression. Reeducated staff on abuse and neglect, resident rights, and care for residents with behaviors, dementia reeducation scheduled for 11/13/2024 with all staff, social worker conducted psychosocial evaluation with no concerns, social worker conducted resident abuse/neglect interviews with no concerns and IDT team met and discussed incident and updated care plans. Conclusion: Confirmed as incident was witnessed. Residents did have a person-to-person interaction with minor skin tears noted and no significant injuries. Resident #2 was a new resident adjusting to his environment. He was assessed by psych services, and they will continue to follow his progress and the medication changes made for Resident #2 was effective.</p> <p>During an interview on 5/14/2025 at 4:45 p.m., CNA E said she heard Resident #3 holler Get the fuck out of my room and she immediately ran down the hall and entered Resident #3's room. She said she saw Resident #2 and Resident #3 on the floor between the bed and the air conditioning unit having an altercation. She hollered for help. She said she and facility staff separated the two Residents and both residents were placed on 1:1 monitoring. She said after the altercation she recalled having to 1:1 monitor Resident #3. She said Resident #3 was upset because Resident #2 was in his room taking his clothes, so they got in a fight. CNA E said she did not see Resident #2 enter Resident #3's room because she was distracted helping the CN and other unit CNA assist a resident that had fallen and was bleeding. CNA E said that Resident #2 was new to the secure unit and a known wanderer, and he should have been monitored to prevent him from wandering into other resident's rooms. CNA E said she had received training regarding redirecting wandering resident from entering other resident's rooms.</p> <p>An attempted telephone interview on 04/29/2025 at 11:10 a.m. with LVN D, the LVN that witnessed the incident, was unsuccessful.</p> <p>During an interview on 04/29/2025 at 2:00 p.m., Resident #3 said Resident #2 came in his room and was taking his clothes. He said he asked Resident #2 to leave but he did not, so they got into an altercation (he hit Resident #2 with his close fist and was hit by Resident #2's closed fist). He said he received scratches and a black eye from the incident.</p> <p>During an interview on 04/29/2025 at 2:20 p.m., Resident #2 stated I don't recall that at all when asked about the incident between him and Resident #3.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. Resident #3 and Resident #4</p> <p>Record review of Resident #3's care plan, effective on 10/23/2024 (post resident-to-resident incident with Resident #2), indicated the resident had behavior problems of agitated behaviors related to wandering residents entering his room. The interventions included separation of residents, 1:1 monitoring, emergency psych visits by psych services. Resident was taken off 1:1, psych services stated resident is not a risk for another altercation, nurses to continue to monitor and document if any behaviors occur.</p> <p>Record review of Resident #3's Resident-to-Resident incident report, dated 11/09/2024, LVN C was summoned by CNA F to Resident #3's room, Resident #3 and Resident #4 were fighting. The nurse entered the room and observed Resident #3 holding another resident (Resident #4) against the wall hitting the other resident several times in the face, appears to be having altercation with another resident. The nurse separated residents. Head to toe assessment initiated, resident denies pain at this time, no injuries noted at this time. Neuro checks initiated. DON, RP, NP, and local police department notified. Resident #3 states he came into my room saying this was his room and my clothes was his clothes. I tried to tell him to leave but he kept taking my stuff. Resident #3 assessed with no injuries observed at the time of incident. Pain level indicated 2. Resident #4 and Resident #3 separated, and Resident #4 placed on 1:1 monitoring.</p> <p>Record review of Resident #4 progress note dated 11/09/2024 at 2:35 p.m. authored by LVN C indicated she was summoned to Resident #3's room by CNA F, Resident #3, and Resident #4 were fighting. Upon entering the room Resident #3 had Resident #4 pinned against the wall, hitting him in the face. LVN C separated residents and assessed for injuries. Resident #4 had scratch to left eyelid with bleeding noted, and bump to left cheek with redness and swelling, treatment provided. Resident #4 denied pain. Resident #4 was placed on 1:1 monitoring. Neuro checks initiated on Resident #4.</p> <p>Record review of Resident #3's skin and wound assessment dated [DATE], indicated Resident #3 had no new wounds.</p> <p>Record review of Resident #4's skin and wound assessment dated [DATE], indicated Resident #4 had two new wounds scratch to left eyelid and bump to his left cheek.</p> <p>Record review of Resident #4's Resident-to-Resident incident report, dated 11/09/2024, LVN C was summoned by CNA F to Resident #3's room, Resident #3 and Resident #4 were fighting. The nurse entered the room and observed Resident #3 Resident #4 against the wall hitting him several times in the face. The nurse and CNA separated residents. Head to toe assessment initiated, resident denies pain at this time. Resident #4 had a bleeding scratch to left eye lid and red, swollen bump to left cheek observed at time of incident. Resident #4 placed on 1:1 and neuro checks initiated. DON, RP, NP, and local police department notified. Resident #4 stated he was in my room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Provider Investigation Report, dated 11/15/2024, incident category as other and other specified as a resident-to-resident incident signed by the DON on 11/15/2024. PIR indicated the incident occurred 11/09/2024 at 2:30 a.m. on the secure unit. PIR indicated CNA F heard Resident #3 yell get the fuck out of my room. She went to assess and observed Resident #3 and Resident #4 tussling in Resident #3's room. CNA F stated that Resident #3 hit Resident #4. CNA F alerted the CN for assistance, and they were separated immediately. Resident #3 had no injuries and Resident #4 had redness and discoloration noted under his left eye and a scratch to his left eyebrow; no hospitalization or further medical treatment was required. Neuro checks were initiated on both residents. The social worker assessed both residents. Post incident interventions included residents on hall were assessed with no concerns noted, staff interviews with no concerns noted, reeducated staff on abuse and neglect, resident rights and care for residents with behaviors, dementia reeducation scheduled for 11/13/2024 with all staff, social worker conducted psychosocial evaluation with no concerns, social worker conducted resident abuse/neglect interviews with no concerns and IDT team met and discussed incident and updated care plans. Resident #4 had medication changes and after continued display of aggressive behaviors was evaluated and admitted to a behavioral hospital on [DATE]. Conclusion: Confirmed that residents did have a person-to-person interaction with no major injury however with a low BIMS these residents were reactive to situation and not intentional to hurt others.</p> <p>During an interview on 04/29/2025 at 2:10 p.m., Resident #3 said Resident #4 came in his room during the night or early morning and demanded Resident #3 to get out of his bed/room and would not leave. He said he defended himself from Resident #4 and he hit Resident #4 trying to get him out of his room.</p> <p>During an interview on 04/29/2025 at 2:45 p.m., Resident #4 stated he does not recall being in an altercation.</p> <p>During an interview on 05/01/2025 at 9:32 a.m., CNA F said she heard Resident #3 holler get the fuck out of my room in the early morning hours of 11/09/2024 so she ran to Resident #3's room and found Resident #3 and Resident #4 shoving each other around and witnessed Resident #4 hit Resident #3 in the face with his hand. CNA F said she separated the residents and redirected Resident #4 back to his room; she said Resident #4 was hard to redirect at times. CNA F said she was the only staff on the secure unit because the other CNA was on break. CNA F said she notified the CN by opening the keypad secure unit doors and hollering for the nurse. CNA F said CN assessed both residents and Resident #4 was placed on 1:1 monitoring. CNA F said that Resident #4 went into Resident #3's room, telling him to get out of his bed/house. CNA F said Resident #4 was a wanderer and had aggressive behaviors at times and Resident #3 did not get aggressive until someone entered his room uninvited and messed with his belongings. NA F said she had received training regarding redirecting wandering resident from entering other resident's rooms prior to incident. CNA F said while she was in Resident #3's room separating the residents and redirecting Resident #4 there was a short timespan that no one was supervising the other residents because she was in the resident's room and not watching the hall.</p> <p>During an interview on 05/05/2025 at 11:07 a.m., LVN C said she was notified by CNA F that Resident #3 and Resident #4 were fighting. She said upon entering the unit, CNA F had already separated the residents. She said Resident #3 said Resident #4 came in his room and was telling him to get out of his bedroom. She said Resident #3 said he told Resident #4 he was in the wrong room, but he got upset. She said Resident #3 said he did defend himself and hit Resident #4. She said she assessed both residents but does not recall what injuries were obtained but she would have documented the injuries and pain in the resident's medical records. She said Resident #4 was placed on 1:1 monitoring.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2025
NAME OF PROVIDER OR SUPPLIER Jefferson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3840 Pointe Parkway Beaumont, TX 77706	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. Resident #2 and Resident #4</p> <p>Record review of Resident #2's care plan, effective on 10/23/2024 (post resident-to-resident altercation with Resident #3), indicated the resident had a resident-to-resident altercation related to dementia/wandering into another resident's room and rummaging through closets. The interventions included emergency psych visits per psych care, increase dosage olanzapine, monitor for agitated behaviors or triggers, and attempt to intervene before an incident occurs, monitor resident while ambulating in the hallways and redirect resident as needed if attempting to enter other residence rooms, and reeducate staff on abuse neglect resident to resident abuse and resident rights.</p> <p>Record review of Resident #4's care plan, effective on 11/09/2024 (post resident-to-resident altercation with Resident #3), indicated the resident had potential to be physically aggressive related to dementia and wandering behaviors with actual aggressive behavior noted due to wandering in another resident's room. The interventions included resident to resident altercation, 1:1 monitoring, administer medications as ordered, assess resident's needs, provide physical and verbal cues to alleviate anxiety, monitor/document/report prn any signs or symptoms of resident posing danger to self or others, when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later and psychiatric/psychogeriatric consult as indicated.</p> <p>Record review of Resident #4 progress note authored by LVN D dated 11/11/2024 at 6:00 a.m., Resident was taken off 1:1 supervision from incident on 11/09/2024. Neuros remain in progress as well as close monitoring. Will continue to monitor.</p> <p>Record review of a Resident-to-Resident incident report, dated 11/11/2024, LVN JJ was informed by CNA V that Resident #4 was on the floor and Resident #2 was on top of him, and they were in a tussling due to Resident #2 entering Resident #4's room. Resident #4 stated, I'm tired of people coming in my room. Residents separated immediately, head to toe assessment initiated, resident denies pain at this time, no injuries noted at this time. Neuro checks initiated. DON, RP, NP, and local police department notified.</p> <p>Record review of Resident #2 progress note dated 11/11/2024 at 6:50 p.m. authored by LVN JJ indicated she was informed that Resident #2 and Resident #4 was on the floor in Resident #4's room tussling due to Resident #2 had entered Resident #4's room without asking. Residents were separated immediately, Resident #2 was a wanderer, assessment completed, no apparent injuries noted.</p> <p>Record review of Resident #2's skin and wound assessment dated [DATE], indicated Resident #2 had no new wounds.</p> <p>Record review of Resident #4 progress note dated 11/11/2024 at 6:54 p.m. authored by LVN JJ indicated she was informed that Resident #4 and Resident #2 was on the floor in Resident #4's room tussling due to Resident #2 entered Resident #4's room without asking. Resident #4 stated I'm tired of people coming in my room. Resident #4 was assessed, no apparent injuries noted. Resident #4 placed on 1:1 monitoring to avoid any aggression to other residents.</p> <p>Record review of Resident #4's skin and wound assessment dated [DATE], indicated Resident #4 had no new wounds.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Jefferson Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3840 Pointe Parkway Beaumont, TX 77706	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Provider Investigation Report, dated 11/18/2024, incident category as other and other specified as a resident-to-resident incident signed by the DON on 11/18/2024. PIR indicated the incident occurred 11/11/2024 at 6:50 p.m. on the secure unit. PIR indicated Resident #2 wandered into Resident #4's room. CNA V heard Resident #4 yell it's you again get out. CNA ran to the Resident #4's room and observed Resident #4 on top of Resident #2 attempting to hit him. CNA V separated the two residents and notified the CN. CN performed head to toe assessment on both residents with no injuries observed and both denied pain. Resident #4 was placed on 1:1 supervision. The MD was contacted and gave orders for Resident #4 to have inpatient behavioral referral. Psych services contacted and performed an evaluation with medication changes. Reeducated staff on abuse and neglect, resident rights, and care for residents with behaviors, dementia reeducation scheduled for 11/13/2024 with all staff, social worker conducted psychosocial evaluation with no concerns, social worker conducted resident abuse/neglect interviews with no concerns and IDT team met and discussed incident and updated care plans. Resident #4 had medication changes and after continued display of aggressive behaviors was evaluated and admitted to a behavioral hospital on [DATE]. Conclusion: Confirmed that residents did have a person-to-person interaction with no major injury however with a low BIMS these residents were reactive to situation and not intentional to hurt others.</p> <p>An attempted telephone interview on 05/13/2025 at 1:10 p.m. with LVN JJ, was unsuccessful.</p> <p>During an interview on 05/13/2025 at 2:25 p.m., Resident #2 stated I don't recall that when asked about the incident between him and Resident #4.</p> <p>During an interview on 05/13/2025 at 2:55 p.m., Resident #4 stated he does not recall being in an altercation, but I do not like people in his room/house.</p> <p>During an interview on 5/14/2025 at 2:00 p.m., CNA V said she was working the secure unit on 11/11/2024, around 6:45 p.m. and as she was in the hallway near the secure unit nurses' station, she recalled seeing Resident #2 standing at the unit entrance double doors (at the opposite end of the hall) looking out the window. CNA V said maybe a minute later she heard it's you again, get out and ran down the hallway to Resident #4's room (first door to the left when entering the unit through the double doors - approx. 91 feet from nurses' station) where she observed Resident #4 on top of Resident #2 trying to hit him. CNA V said she did not witness anyone get hit but they were both on the floor. CNA V said she followed training she had been provided and separated them immediately and she had to open the keypad secure unit doors and hollered for the nurse for assistance due to resident-to-resident altercation. CNA V said she was on the secure unit alone at the time of the incident because the other CNA was on break. NA V said that if staff is leaving the unit that CN and other staff should be notified, should always be one staff on the secure unit to monitor residents. CNA V said she had received training regarding redirecting wandering resident from entering other resident's rooms. She said the CN sat at the nurses' station outside the secure unit after 6:00 p.m. because she had to monitor another hall other than the secure unit.</p> <p>4. Resident #2 and Resident #3</p> <p>Record review of Resident #2's, effective on 10/23/2024, indicated the care plan was not updated post a resident-to-resident altercation on 11/11/2024 involving Resident #4.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's care plan, effective on 11/09/2024, indicated the resident had behavior problems of agitated behaviors related to wandering residents entering his room. The interventions included resident to resident altercation, staff to redirect wandering residents from entering Resident #3's room, separation of residents, 1:1 monitoring, emergency psych visits by psych services if applicable.</p> <p>Record review of Resident #2 progress note dated 11/23/2024 at 5:33 p.m. authored by LVN G indicated she was notified by CNA H that Resident #2 was in Resident #3's room taking Resident #3's snacks and Resident #3 confronted Resident #2 and was pushing him out of his room and during the altercation they both fell, landing on their buttocks. Resident #2 and Resident #3 was attempting to hit and kick each other but staff was able to intervene before resident's could make contact. Residents were separated. Resident #2 shrugged his shoulders when asked what happened and continued to eat snack cake, he took from Resident #3's room. Residents separated and assessed for injuries and denied pain and showed no nonverbal indicators of discomfort.</p> <p>Record review of a Resident-to-Resident incident report, dated 11/23/2024, indicated CNA H noted Resident #3 was pushing Resident #2 out of his room and onto the floor. Resident #2 landed on his buttocks. Resident #3 lost his balance and landed on his buttocks while attempting to grab Resident #2 and yelling he's stealing. Once on the floor Resident #2 and Resident #3 continued to attempt to hit and kick one another. Staff able to intervene before resident's could make contact. Resident #2 had a snack cake in his hand and once assist off floor walked off eating cake. Resident #3 stated Resident #2 came into his room and took his snacks and started eating them. Resident #3 assessed with no injuries observed at the time of incident. No pain indicated. Resident #3 was placed on 1:1 monitoring.</p> <p>Record review of Resident #3 progress note dated 11/23/2024 at 5:01 p.m. authored by LVN G indicated CNA H notified her that Resident #3 was pushing Resident #2 out of his room and during the altercation they both fell, landing on their buttocks. Resident #3 was yelling he's stealing. Resident #2 and Resident #3 were attempting to hit and kick each other but staff was able to intervene before resident's could make contact. Residents were separated. Resident #3 said Resident #2 came in his room and started eating his snacks. Residents separated and assessed for injuries and denied pain and showed no nonverbal indicators of discomfort. LVN G received new lab orders for Resident #3 and to start Depakote 250 mg twice a day to help with agitation and mood stabilization.</p> <p>Record review of Resident #3's skin and wound assessment dated [DATE], indicated Resident #3 had no new wounds.</p> <p>Record review of the facility's Provider Investigation Report, dated 11/27/2024, incident category as other and other specified as a resident-to-resident incident signed by the DON on 11/27/2024. PIR indicated the incident occurred 11/23/2024 at 2:40 p.m. on the secure unit. PIR indicated Resident #3, and Resident #4 had a resident-to-resident incident, both resided on the secure unit with low BIMS and wandering behaviors. Resident #2 wandered into Resident #3's room and proceeded to rummage in his Resident #3 bedside table snacks. Resident #3 attempted to get Resident #2 out of his room by pushing him[TRUNCATED]</p>		