

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 05/30/2024
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 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214</p> <p>Based on interview and record review, the facility failed to complete a discharge resident assessment within the required time frame for 1 of 25 residents (Resident #39) reviewed for MDS (Minimum Data Set) completion.</p> <p>The facility failed to complete and transmit a required discharge assessment for Resident #39 within 14 days after Resident #39 discharged from the facility.</p> <p>This failure could place residents at risk of not getting continuity of care, if their clinical and discharge assessment information was not current and accurate in the MDS (RAI) database.</p> <p>Findings included:</p> <p>Record Review of Resident #39's face sheet dated 05/24/24 indicated she was a [AGE] year-old female admitted on [DATE] with diagnoses that included: cerebral infarction (brain tissue damage caused by lack of oxygen to the area), aphasia (a language disorder that occurs when parts of the brain are damaged), and peripheral vascular disease (a progressive disorder that reduces blood circulation to parts of the body other than the brain or heart).</p> <p>Record review of the last quarterly MDS dated [DATE] indicated Resident #39 was severely cognitively impaired and required substantial/maximal assistance for ADLs. There was no evidence of a discharge MDS assessment.</p> <p>Record review of the MDS summary sheet dated 05/30/24 for Resident #39 indicated discharge Assessment Reference Date (ARD): 01/09/24, 128 days overdue.</p> <p>Record review of a Discharge Summary form dated 02/06/24, signed by the physician indicated Resident #39 was discharged from the facility on 01/09/24 to a hospital.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/30/24 at 11:44 a.m., MDS Nurse A said she was responsible for completing the MDS assessments for Resident #39. She said MDS Nurse C was her back up to double check MDS assessments for accuracy and completeness. MDS Nurse A said she had been working as an MDS Nurse for [AGE] years and had attending many trainings on MDS accuracy, completeness, and completing MDS assessments timely. She said Resident #39's discharge MDS had never been completed or transmitted and she should have had a discharge assessment completed when she left the facility, but it was just missed. She said the possible negative outcome for not completing a discharge MDS assessment was the facility was still receiving quality measures (information on a number of aging-relevant domains including: functional and cognitive status, psychosocial functioning, geriatric syndromes, and life care wishes) related to Resident #39 when she was no longer at the facility.</p> <p>During an interview on 05/30/24 at 12:01 p.m., the Administrator said her expectation was for all MDS assessments to be completed timely and correctly. She said the MDS Nurses were responsible for completing all assessments including Resident #39's discharge assessment. The Administrator said the discharge assessment was just missed. She said the facility also contracted with an MDS consultant firm that oversees and audits the MDS assessments completed by the facility. She said that after learning of the errors occurring in the facility's MDS assessments, she was planning to get the MDS Nurses additional training to ensure all MDS assessments would be completed timely and accurately.</p> <p>During an interview on 05/30/24 at 12:07 p.m., the DON said a discharge MDS assessment should have been completed for Resident #39. He said the discharge assessment was just overlooked. He said the MDS Nurses receive information daily about discharged or hospitalized residents through the facility's daily care meetings. He said his expectation was that all MDS assessments be completed accurately and timely. He said the facility did not have a policy on MDS assessments but followed the Long-Term Care for Resident Assessment Instrument (RAI).</p> <p>Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 updated October 2023 indicated, .Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by CMS. The requirements for the RAI are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. They include: . Discharge (return not anticipated or return anticipated). discharge assessment - return not anticipated . MDS completion date is no later than discharge date +14 calendar days. and must be submitted 14 days after the MDS completion date.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779</p> <p>Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for 3 of 25 residents reviewed for assessments. (Residents #1, #36 and #85).</p> <p>The facility failed to complete an accurate resident assessment for Resident #1. Resident #1's resident assessment did not indicate she smoked.</p> <p>The facility did not ensure Resident #36's MDS assessment reflected he was on oxygen.</p> <p>The facility failed to complete an accurate resident assessment for Resident #85. Resident #85's resident assessment did not indicate he was on hospice services.</p> <p>These failures could place residents at risk of not having their individual needs met and a decreased quality of life.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 05/28/24 indicated Resident #1 was a [AGE] year-old female readmitted on [DATE]. Her diagnoses included schizoaffective disorder (mental illness that can affect your thoughts, mood, and behavior) and major depressive disorder (mental condition characterized by persistently depressed mood and long-term loss of pleasure or interest in life).</p> <p>Record review of the most recent Smoking Safety Screen dated 10/26/23 indicated Resident #1 understood all tobacco products would be kept by facility staff, she would be supervised by facility staff and could light her own cigarettes.</p> <p>Record review of a comprehensive MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 9, indicating her cognition was moderately impaired and had diagnoses of schizoaffective disorder and major depressive disorder. The MDS was not marked for current tobacco use.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 9 indicating her cognition was moderately impaired.</p> <p>Record review of a care plan revised 05/13/24 indicated Resident #1 was a smoker and required supervision while smoking.</p> <p>Record review of an undated smokers list indicated Resident #1 smoked.</p> <p>During an observation and interview on 05/29/24 at 11:11 a.m., Resident # 1 was smoking a cigarette with steady hands. Resident #1 said she smoked every day, sometimes 5 times a day. She said she has smoked since she got to the facility.</p> <p>During an interview on 05/29/24 at 2:45 p.m., LVN B said she was providing care for Resident #1 today. She said Resident #1 smoked daily and the facility kept her smoking supplies for her.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/29/24 at 3:00 p.m., MDS Nurse A said she was responsible for MDS's with Medicaid as the payor source. She said Resident #1 smoked daily. She said Resident #1's MDS on 01/04/24 should have been marked for smoking and was not. She said she overlooked it. MDS Nurse A said she would correct the MDS after surveyor intervention. She said she was educated on MDS accuracy with October being her most recent update on the MDS. MDS Nurse A said the risk of not documenting smoking on a resident's MDS was possibly a smoking assessment not getting completed.</p> <p>Record review of the RAI section J 1300 Code 1 indicated yes; if the resident or any other source indicates that the resident used tobacco in some form during the look back period.</p> <p>2. Record review of physician orders dated May 2024 indicated Resident #36, readmitted [DATE], was a [AGE] year-old male with a diagnosis of cerebral infarction related to thrombosis of the carotid artery (rare but serious condition in which a blood clot forms in the cerebral artery blocking blood circulation in the brain tissue). The resident was ordered oxygen at 2 LPM by NC continuously every shift for shortness of breath, active 05/21/2024.</p> <p>Record review of the MARs for Resident #36 dated March 2024, April 2024 and May 2024 indicated Resident #36 received oxygen 2L NC continuously daily as ordered.</p> <p>Record review of significant change MDS assessment dated [DATE] indicated Resident #36 had a BIMS of 99 (severe cognitive impairment) and did not receive oxygen.</p> <p>Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #36 had a BIMS of 00 (severe cognitive impairment) and did not receive oxygen.</p> <p>Record review of a care plan date initiated 01/24/24 indicated Resident #36 received oxygen therapy. The goal was that the resident would not have poor oxygen absorption.</p> <p>During observations, Resident #36 had oxygen at 2L NC in progress:</p> <p>*05/28/24 at 9:53 a.m.,</p> <p>*05/29/24 at 8:18 a.m.,</p> <p>*05/29/24 at 10:40 a.m.,</p> <p>*05/29/24 at 3:26 p.m., and</p> <p>*05/30/24 at 8:41 a.m.</p> <p>During an interview on 05/30/24 at 8:52 a.m., MDS Nurse A said Resident #36 was on oxygen. She said she was responsible for ensuring the MDS assessments were accurate. She said Resident #36's MDSs dated 01/26/24 and 4/27/24 did not capture the resident's oxygen and should have. She said the MDS guided the resident's care and the possible negative outcome of not capturing the resident's oxygen would be he may not receive the services he required.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/30/24 at 9:05 a.m., the DON said his expectations were for the MDS documentation to be accurate. He said the possible negative outcome could be the resident may not receive the care and services he required.</p> <p>Record review of the RAI section O 0100C indicated: Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia (deficiency in the amount of oxygen reaching the tissues) in this item.</p> <p>3 Record review of a face sheet dated 05/29/24 indicated Resident #85 was a [AGE] year-old male admitted on [DATE]. His diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), dementia (loss of cognitive functioning), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), hypertension (condition in which the force of the blood against the artery walls is too high), hypertensive heart disease (caused by chronically high blood pressure), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), and depression (mental illness that negatively affects how you feel, the way you think and how you act).</p> <p>Record review of physician orders for May 2024 indicated Resident #85 had an order dated 01/15/24 for hospice care.</p> <p>Record review of a care plan dated 10/31/23 indicated Resident #85 had a terminal prognosis related to heart disease and was on hospice services.</p> <p>Record review of the quarterly MDS assessment dated [DATE] for Resident #85 indicated it was not marked for hospice while a resident. The MDS form indicated the section for hospice was signed by MDS Nurse A.</p> <p>During an interview on 05/29/24 at 02:48 p.m., MDS Nurse A said Resident #85 was still on hospice services. She indicated she just did not mark that he was on hospice.</p> <p>During an interview on 05/29/24 at 3:25 p.m., the DON said MDS Nurse A and C were responsible for all MDSs in the facility. He said Resident #1 was a smoker. The DON said Resident #1's MDS should have been documented for smoking. He said it was an oversight. The DON said he was responsible for signing MDS for completion and he checked triggered items but not the whole MDS for accuracy. He said the risk of smoking not captured on the MDS was the facility not paid accurately and a change may not be captured. The DON said his expectation was accuracy on all MDS.</p> <p>During an interview on 05/29/24 at 3:37 p.m., the Administrator said Resident #1 smoked. She said MDS nurse B and C were responsible for completing all MDS in the facility. She said the Regional Care Manager was the back-up. She said the risk of smoking not documented on the MDS was the MDS may not give a complete and accurate picture of the resident. She said her expectation was MDSs completed accurately, completely, and timely.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/30/24 at 11:55 a.m., Regional Care Manager said MDS Nurse A and C were responsible for all MDS in the facility. She said she was the consultant and did yearly audits and spot checked MDSs. The Regional Care Manager said she educated MDS Nurse A and C though out the year on the RAI (Resident Assessment Instrument). She said Resident #1's MDS not documented for smoking was overlooked. She said the risk of smoking not documented on the MDS was the resident may not match the plan of care and possibly conflict with care provided.</p> <p>During an interview on 05/30/24 at 08:40 a.m., the DON said they did not have an MDS policy, they followed the RAI manual.</p> <p>Record review of the, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated, October 2023, indicated, . J11300: Current Tobacco Use Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. I the resident states that they used tobacco in some form during the 7-day look back period, code 1, yes. Code 1 yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.</p> <p>30664</p> <p>41057</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460</p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs to meet the needs of each resident for 1 of 9 residents reviewed for medication administration. (Residents #54)</p> <p>The facility failed to ensure LVN D mixed crushed tablets with 5-10 cc of warm water prior to administering medications to Resident #54's G-tube (Gastrostomy tube-tube surgically inserted through the skin into the stomach) per facility policy.</p> <p>These failures could place residents at risk of not receiving the desired therapeutic effects of their medications and residents with G-tubes at risk of tube clogging/obstruction, medical complications, or a decline in health due to inappropriate G-tube care, management, and not following appropriate procedures.</p> <p>Findings included:</p> <p>Record review of the face sheet dated 05/29/24 indicated Resident #54 was [AGE] year-old female admitted on [DATE] with diagnoses gastrostomy, heart failure and stroke.</p> <p>Record review of physician orders dated 05/29/24 indicated Resident #54's orders included an enteral (through an artificial opening into the stomach) order every shift flush feeding tube with 30 cc of water before and after medication administration and may crush medications and or open capsules per pharmacy guidelines.</p> <p>Record review of annual MDS assessment dated [DATE] indicated Resident #54 had unclear speech was rarely/never understood or rarely/never understands. Resident#54 required feeding tube while she was a resident and during the last 7 days received greater than 51 percentage of calories per artificial means.</p> <p>Record review of the care plan with revision date of 04/30/24 Indicated Resident #54 was at risk for being unable to swallow, the feeling of food stuck in throat or food coming back up due to difficulty in swallowing requiring patient to have feeding tube with Jevity (tube feeding formula)1.5 @70 ml/hr. x 18 hrs with water flushes of 40 ml/hr. x 18 hrs and med flushes. The interventions included resident required total assistance with tube feeding and water flushes.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 05/29/24 at 08:03 a.m., LVN D crushed 7 medications for Resident #54 and placed each into an individual 30 cc medication cup. She poured 120 cc of water into 240 cc glass and poured a cap full of clear lax (a laxative to help the bowels move) into the water. She poured 7.5 cc iron supplement into a 30 cc medication cup and opened 2 capsules and placed them in separate 30 cc medication cups. LVN D checked the placement with aspiration of the G-tube for Resident #54 then flushed the tube with 30 cc of water. LVN D then poured 30 cc of water in the syringe before and after each dry medications one at a time into the syringe attached and swirled the syringe as it was infusing to Resident #54 through her G-tube without mixing each dry medication with 5-10 cc of warm water . LVN D put 30 cc of water and the dry capsule content into the syringe and used a swirling motion with the syringe and milked the G-tube with her other hand and followed with another 30 cc of water after each medication. LVN D clamped the G-tube.</p> <p>During an observation and interview on 05/29/24 at 4:00 p.m., LVN D crushed the medications for Resident #54 and mixed each crushed medication with 10 cc warm water. LVN D checked Resident #54's G-tube with aspiration and then poured 30 cc of water then poured the dissolved medications into the syringe then flushed with 30 cc of water. LVN D said she had been given an in-service on G-tube medication administration. LVN D said the facility policy was to mix crushed medications with 5-10 cc warm water to prevent the G-tube from clogging.</p> <p>During an interview on 05/30/24 at 8:46 a.m., the DON said their policy was to crush medications and mix with 5-10 cc of warm water however he said he had called the pharmacist and the Pharmacy Consultant said it was not necessary to allow medications to dissolve prior to administration. The DON provided a letter from the Pharmacy Consultant and the facility policy.</p> <p>Record review of a letter dated 05/29/24 from the Pharmacy Consultant to the DON indicated the Pharmacy consultant wrote the guidelines did not include let the medication completely dissolve after being crushed before administering .</p> <p>Record review of the policy dated 10/01/19 titled Enteral Tube (artificial opening into the stomach) Medication Administration indicated The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. 2. Tablets that must be crushed prior to administration via feeding tubes require specific order related to crushing. B. Crush immediate release tablets into a fine powered and dissolve in 5-10 cc (ml is the same as cc) of warm water, . L. Pour dissolved/dilute medication in syringe allowing medication to flow by gravity.</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214</p> <p>Based on observation, interview, and record review, the facility failed to follow their own established smoking policy for 1 of 4 residents (Resident #1) reviewed for smoking.</p> <p>The facility failed to follow their policy on smoking by not completing a smoking safety screen assessment quarterly on Resident #1.</p> <p>This failure could place residents at risk of unsafe smoking and injury.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 05/28/24 indicated Resident #1 was a [AGE] year-old female readmitted on [DATE]. Her diagnoses included schizoaffective disorder (mental illness that can affect your thoughts, mood, and behavior) and major depressive disorder (mental condition characterized by persistently depressed mood and long-term loss of pleasure or interest in life).</p> <p>Record review of the most recent Smoking Safety Screen dated 10/26/23 indicated Resident #1 understands all tobacco products will be kept by facility staff and be supervised by facility staff and can light her own cigarettes.</p> <p>Record review of a comprehensive MDS dated [DATE] indicated Resident #1 was usually understood, usually understands, had a BIMS score of 9 indicating she had moderately impaired cognition and had diagnoses of schizoaffective disorder and major depressive disorder. The MDS was not marked for current tobacco use. Resident #1's MDS indicated she needed set up assistance with eating and oral hygiene and supervision for toileting, dressing and bathing.</p> <p>Record review of a quarterly MDS dated [DATE] indicated Resident #1 was usually understood, and had a BIMS score of 9, indicating she had moderately impaired cognition. Resident #1's MDS indicated she needed set up assistance with eating and oral hygiene and supervision for toileting, dressing and bathing.</p> <p>Record review of a care plan revised 05/13/24 indicated Resident #1 was a smoker and required supervision while smoking. The interventions of the care plan were for staff to instruct Resident #1 about the facility policy on smoking: locations, times, and any safety concerns.</p> <p>Record review of an undated smokers list indicated Resident #1 smoked.</p> <p>During an observation and interview on 05/29/24 at 11:11 a.m., Resident # 1 was smoking a cigarette with steady hands. Resident #1 said she smoked every day, sometimes 5 times a day. She said she had smoked since she got to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/29/24 at 2:45 p.m., LVN, B said she was providing care for Resident #1. She said Resident #1 smoked daily and the facility kept her smoking supplies for her. LVN B said the nurses were responsible for quarterly smoking assessments. She said the smoking assessment for Resident #1 was not showing due in the computer system and she was unsure what happened. LVN B said the nurses assess Resident #1 daily for a change in condition, notify the DON and physician of changes. She said there is no risk to the resident of not completing a quarterly smoking assessment since the resident was assessed daily for changes.</p> <p>During an interview on 05/29/24 at 3:02 p.m., the SW said Resident #1 was a smoker and listed on the smoking list. The SW said she was responsible for completing the smoking assessment on admission. She said the nurses were responsible for completing the quarterly smoking assessments. The SW said she could complete a change in status smoking assessment. She said she updates the smoking list with any changes.</p> <p>During an interview on 05/29/24 at 3:25 p.m., the DON said Resident #1 was a smoker. He said the smoking assessments not completed after 10/26/23 should have been completed quarterly. The DON said the nurses were responsible for the admission smoking assessment and the SW was responsible for completing quarterly smoking assessments. He said the nurses could also do them quarterly. The DON said it was a system error for smoking assessments not to trigger due in the computer system. He said the risk of not completing smoking assessments quarterly was an inaccurate assessment and a possible change not captured. The DON said his expectation was smoking assessments be completed quarterly and as needed.</p> <p>During an interview on 05/29/24 at 3:37 p.m., the Administrator said Resident #1 smoked. She said the smoking assessments not completed quarterly was a system error. The Administrator said she was not sure if the MDS was not triggered for smoking or if someone clicked or unclicked a button in the computer system to not trigger the smoking assessment to be completed. She said the risk of not completing a smoking assessment quarterly was a possible missed change. The Administrator said her expectation was smoking assessments completed accurately and timely.</p> <p>During an interview on 05/30/24 at 11:55 a.m., Regional Care Manager, said the SW was responsible for manually triggering the smoking quarterly assessments in the computer system.</p> <p>Record review of a facility policy revised 09/14 titled, Smoking/ Tobacco Policy indicated, . Evaluation, Plan of Care and Summary 6. Smoking/ Tobacco Evaluation, Plan of Care and Summary to be completed upon admission, quarterly, annual and for change of condition assessment.</p>		