STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675620	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Nursing and Rehabilitation	1175 Denton Dr Beaumont, TX 77707

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47879 Based on interview and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation for 2 of 5 employees (LVN O & LVN T) reviewed for develop and implement abuse policies. The facility failed to ensure the Administrator implemented the facility's abuse/neglect policy and procedure when she failed to document suspension timeframes and advise the employees of the outcomes of the investigation in the determination of disciplinary action and/or reinstatement. The facility failed to document suspension time frames and advise the employee of the investigation outcome when LVN O allegedly verbally abused Resident #2 on 10/14/2024. The facility failed to document suspension time frames and advise the employee of the investigation outcome when LVN T allegedly secluded residents in the TV room of the secure unit on 10/25/2024. This failure could place residents at risk for abuse, neglect and/or exploitation. Findings included: Record review of the facility's policy Abuse/Neglect, date revised 03/29/2018, indicated . F. Investigation . 4. With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee(s) will immediately be suspended pending an investigation. The employee will have an opportunity to present a written statement to answer the allegation(s) of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The employee will have the opportunity to be advised of the outcome of the investigation in the determination of disciplinary action and/or reinstatement. 5. Abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property of residents by employees of any facility will be grounds for immediate termination. 6. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s). A copy of the written report will accompany any personnel action deemed necessary. If a personnel action occurs, a copy of all pertinent documents will be placed in the employee's personnel file. 7. The facility will report and cooperate with any and all investigations concerning reports of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source by the company's employees as set forth in state law (including to the state survey and certification agency). (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the employee disciplinary report for LVN O indicated the employee was placed on an investigation suspension pending an investigation into allegation of abuse with the date of infraction of 10/24/2024. LVN O was placed on unpaid investigation suspension. LVN O will remain on investigation suspension until the investigation is completed into the abuse allegation. LVN O will be notified when the investigation is completed. If the investigation does no substantiate any wrong, LVN O will receive pay retro for any shifts they may have missed while on suspension on the next payroll date. LVN O ma provide a written statement regarding the allegations under investigation. LVN O may not use PTO or PDO for their suspension days. Employee Comments (may be submitted to the supervisor presenting the EDR within 5 days of presentation of EDR), indicated no comments from LVN O. Report signed by DON, the Administrator and LVN O on 10/25/2024. Record review of LVN O's personnel files did not indicate suspension time frames or advisement to the employee of the investigation outcome when LVN O allegedly verbally abused Resident #2 on 10/14/2024. Record review of the employee disciplinary report for LVN T indicated the employee was placed on an investigation suspension pending an investigation into allegation of abuse with the date of infraction of 10/24/2024. LVN T was placed on unpaid investigation suspension. LVN T will remain on investigation suspension until the investigation is completed into the abuse allegation. LVN T will be notified when the investigation is completed. If the investigation does no substantiate any wrong, LVN T will receive pay retro for any shifts they may have missed while on suspension on the next payroll date. LVN T ma provide a written statement regarding the allegations under investigation. LVN T may not use PTO or PDO for their suspension days. Employee Comments (may be submitted to the supervisor presenting the EDR within 5 days of presentation of EDR), indicated no comments from LVN T. Report signed by DON, the Administrator and LVN T on 10/25/2024. Record review of LVN T's personnel files did not indicate suspension time frames or advisement to the employee of the investigation outcome when LVN T allegedly secluded secure unit residents in the TV room on 10/25/2024. During an interview on 2/13/2025 at 2:00 p.m., LVN O said she was aware of alleged abuse allegations against her and said she was suspended during the investigation process but does not recall how long she was suspended nor the dates of suspension. LVN O denied she verbally abused Resident #2 and witnesses confirmed she did not verbally abuse Resident #2. LVN O said she was suspended and later received a phone call the investigation was completed, and she could return to work. LVN O denied being offered or told the investigation outcome. Attempted to interview LVN T on 02/12/2025 @ 5:30 p.m. and 02/13/2025 at 12:30 p.m., voice message left, and no return call received during the investigation survey. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2025 at 4:15p.m., the Administrator said the allegation of LVN O speaking rudely and loudly to Resident #2 was unfounded. The Administrator said the incident happened at shift change on 10/14/2024 and LVN O left. The Administrator said after reviewing the witness statements and conducting interviews on 10/14/2024 it was determined Resident #2 was not verbally abused by LVN O. The Administrator said Resident #2 was not aware of the incident and LVN O did not have direct verbal contact with Resident #2, so she did not report the allegation. The Administrator said when she was discussing the allegation with her ADO on 10/24/2024 she was informed the allegation should have been reported to the State Agency, so she reported the allegation at that time. The Administrator said when an abuse allegation occurs and staff involved, the information is submitted to the corporate staff and the employee disciplinary report is completed by the corporate staff and returned to her for review and completion. The Administrator said she reviews and discussed the disciplinary reports with the employees and had them sign and date the report. The Administrator said she did not recall the disciplinary report/form having a section to include the suspension dates just the date of infraction or a section for employee advisement of the outcome. The Administrator said when the investigation is completed, she notifies the employee if they are released to returned to work or terminated which is related to the outcome. The Administrator said not investigating and documenting information on employee disciplinary report could cause the staff to not be aware of the outcomes or make staff aware of the infraction, so it does not happen again. The Administrator said not investigating the alleged abuse and following facility disciplinary policies could place residents at risk for further abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse were reported, immediately but not later than 2 hours after the allegation was made, if the events that cause the allegation involves abuse or results in serious bodily injury, to the State Survey Agency for 1 of 4 residents (Residents #2) reviewed for reporting allegations of abuse. The facility failed to report an allegation of abuse within 2 hours after LVN O allegedly verbally abused Resident #2 on 10/14/2024. The failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of Resident #2's Admission Record dated 02/12/2025 indicated he was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses which included profound intellectual disabilities (severe disability which limits a person's ability to learn, communicate, and live independently), atrial fibrillation (a type of irregular heartbeat), muscle weakness, heart failure (serious condition occurs when the heart can't pump enough blood and oxygen to the body), hypertension (condition in which the force of the blood against the artery walls is too high), and diabetes (chronic condition affecting the way the body processes blood sugar). Record review of Resident #2's admission MDS assessment, dated 09/26/2024, indicated resident had intellectual disabilities and was rarely or never understood and a brief interview for mental status (BIMS) was not conducted. He had continued behaviors of inattention and disorganized thinking. The Functional abilities self-care indicated he was independent with eating, oral care, upper body dressing and required moderate assistance with shower/bathing and lower body dressing. The Functional abilities mobility indicated he was independent with all tasks except toilet transfers which required supervision or touching assistance and car transfer was not applicable. Record review of Resident #2's care plan, dated 09/17/2024, indicated he had impaired cognitive function/dementia or impaired thought processes. Interventions included communication techniques, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal indications, and report to MD if changes were identified. During an observation on 02/11/2025 at 11:30 a.m., Resident #2 ambulated to the dining room using a walker. He appeared well groomed with no foul odors and no signs of abuse or neglect were identified. Resident #2 interacted with facility staff with no indication of fear or discomfort. Unable to interview Resident #2 due to his severely impaired cognition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Provider Investigation Report dated 10/24/2024 indicated on 10/14/2024 at 1:50 p.m., a staff member called and texted the Administrator regarding an incident that occurred with Resident #2 and LVN O. The allegation was LVN O hollered loudly at Resident #2 to stop singing. The Administrator requested witness statements from the facility staff involved and/or observed the incident. Resident #2 was interviewed, assessed, and monitored following the incident with no adverse findings. The Investigation Findings indicated it was unfounded after talking with the resident and the witness statements provided. It was determined LVN O did not tell Resident #2 to stop singing, she just asked co-workers who were making the noise or singing. Per the witnesses, Resident #2 was likely not within hearing range at the time. The Agency Action Post-Investigation included in-service performed on all staff on abuse and neglect, resident rights, code of conduct and professionalism, and timely reporting of allegations. The date and time reported to HHSC was on 10/24/2024 at 8:24 p.m. (10 days after the incident was initially reported). During an interview on 02/13/2025 at 4:15 p.m., the Administrator said the allegation of LVN O speaking rudely and loudly to Resident #2 was unfounded. The Administrator said the incident happened at shift change on 10/14/2024 and LVN O left. The Administrator said after reviewing the witness statements and conducting interviews on 10/14/2024 it was determined Resident #2 was not verbally abused by LVN O. The Administrator said Resident #2 was not aware of the incident and LVN O did not have direct verbal contact with Resident #2, so she did not report the allegation. The Administrator said when she was discussing the allegation with her ADO on 10/24/2024, she was informed the allegation should have been reported to the State Agency, so she reported the allegation at that time. The Administrator said the allegation should have been reported within 2 hours of the allegation and then investigated. The Administrator said not reporting and investigating the alleged abuse could place residents at risk for further abuse. Record review of the facility's policy Abuse/Neglect, date revised 03/29/2018, indicated .Reporting 1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. 2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 8/29/2024. a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview, and record review, the facility failed investigate and report the findings of the investigation to the State Survey Agency within 5 working days of the incident for 1 of 4 residents (Residents #2) reviewed for abuse. The facility failed to investigate and submit the results of their investigation within 5 days after LVN O allegedly verbally abused Resident #2 on 10/14/2024. These failures could place residents at risk of abuse, physical harm, mental anguish and emotional distress. Findings included: Record review of Resident #2's Admission Record dated 02/12/2025 indicated he was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses which included profound intellectual disabilities (severe disability which limits a person's ability to learn, communicate, and live independently), atrial fibrillation (a type of irregular heartbeat), muscle weakness, heart failure (serious condition occurs when the heart can't pump enough blood and oxygen to the body), hypertension (condition in which the force of the blood against the artery walls is too high), and diabetes (chronic condition affecting the way the body processes blood sugar). Record review of Resident #2's admission MDS assessment, dated 09/26/2024, did not indicated a BIMS score identified resident was rarely/never understood and interview not obtained, and he was rarely/never able to make himself understood and rarely/never understood others. He was frequently incontinent of bowel and bladder. The Functional abilities self-care indicated he was independent with eating, oral care, upper body dressing and required moderate assistance with shower/bathing and lower body dressing. The Functional abilities mobility indicated he was independent with all tasks except toilet transfers which required supervision or touching assistance and car transfer was not applicable. Record review of Resident #2's care plan, dated 09/17/2024, indicated he had impaired cognitive function/dementia or impaired thought processes. Interventions included communication techniques, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal indications, and report to MD if changes identified. During an observation on 02/11/2025 @ 11:30 a.m., Resident #2 ambulating to dining room using walker, appears well groomed with no foul odors and no signs of abuse or neglect identified. Resident #2 interacts with facility staff with no indication of fear or discomfort. Unable to interview Resident #2 due to his severely impaired cognition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Provider Investigation Report dated 10/24/2024 indicated on 10/14/2024 at 1:50 p.m., A staff member called and texted the Administrator regarding an incident occurred with Resident #2 and LVN O. The allegation was LVN O hollered loudly at Resident #2 to stop singing. The Administrator requested witness statements from the facility staff involved and/or observed the incident. Resident #2 was interviewed, assessed, and monitored following the incident with no adverse findings. The Investigation Findings indicated it was unfounded after talking with the resident and the witness statements provided, it was determined LVN O did not tell Resident #2 to stop singing, she just ask co-workers who was making the noise or singing. Per the witnesses, Resident #2 may not have been within hearing range at the time. The Agency Action Post-Investigation included room changes made would remain permanent, psych evaluations in-service performed on all staff on abuse and neglect, resident rights, code of conduct and professionalism, and timely reporting of allegations. The date and time reported to HHSC was on 10/24/2024 at 8:24 p.m. (10 days after the incident was initially reported). During an interview on 02/13/2025 at 4:15p.m., the Administrator said the allegation of LVN O speaking rudely and loudly to Resident #2 was unfounded. The Administrator said the incident happened at shift change on 10/14/2024 and LVN O left. The Administrator said after reviewing the witness statements and conducting interviews on 10/14/2024 it was determined Resident #2 was not verbally abused by LVN O. The Administrator said Resident #2 was not aware of the incident and LVN O did not have direct verbal contact with Resident #2, so she did not report the allegation. The Administrator said when she was discussing the allegation with her ADO on 10/24/2024 she was informed the allegation should have been reported to the State Agency, so she reported the allegation at that time. The Administrator said the abuse allegation should have been reported to HHSC within 2 hours of the allegation and the provider investigation report should have been sent to HHSC no later than 5 working days after the incident or initial report. The Administrator said not reporting and investigating the alleged abuse could place residents at risk for further abuse. Record review of the facility's policy Abuse/Neglect, date revised 03/29/2018, indicated . F. Investigation . 1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC. 2. After receipt of the allegation the Abuse Preventionist and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines found in Provider letter 19-17.3. A report to the appropriate agency will include the following: the name and address of the suspected victim; the name and address of the suspected victim's care giver, if known; the nature and extent of any injuries resulting from the suspected abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injury of unknown source; the nursing facility will make an addendum to any reportable incident in its report to HHSC if the resident subsequently experiences a negative outcome; other pertinent information as available. The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 4 residents reviewed for accidents and supervision. (Resident #1) The facility failed to provide adequate supervision for Resident #1 who was assessed as a high risk for elopement. On 11/08/2024 he was allowed to sit on the front porch without supervision, and facility received a phone call from another resident's family member informing facility Resident #1 was at the end of the facility's exit driveway entering the residential roadway. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 11/02/2024 and ended on 11/08/2024. The facility had corrected the non-compliance before the survey began. This failure could prevent residents from receiving appropriate supervision which could lead to resident sustaining serious injury or harm. Findings included: Record review of Resident #1's Admission Record dated 02/12/2025 indicated he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included congestive heart failure systolic (condition in which the heart's main pumping chamber (left ventricle) is weak), cognitive communication deficit (communication difficulty stems from an impairment in cognitive processes, these deficits can impact a person's ability to think, speak, listen, read, and interact with others), hypertension (condition in which the force of the blood against the artery walls is too high), chronic obstructive pulmonary disease (a lung disease blocks airflow making it difficult to breathe), diabetes mellitus (chronic condition affects the way the body processes blood sugar), transient cerebral ischemic attack (temporary interruption of blood flow to the brain causes stroke-like symptoms resolve within 24 hours) and cataract, left eye (common eye condition characterized by the clouding and thickening of the natural lens in the eye, leading to decreased vision). Record review of a quarterly Elopement Risk assessment dated [DATE] indicated Resident #1 was a low risk for elopement with a score of 7. The form was signed by the DON. Record review of Resident #1's quarterly MDS assessment, dated 08/09/2024, indicated a BIMS score of 04 which indicated he was severely impaired cognitively and he was able to make himself understood and understood others. He was always continent of bowel and bladder. The Functional self-care assessment indicated he required moderate assistance with toileting hygiene, shower/bath, lower body dressing, putting on/taking of shoes, personal hygiene, and setup or clean up assistance for eating, oral hygiene, and upper body dressing. The Functional mobility assessment indicated he required moderate assistance for lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and walking 50 feet with two turns. He required supervision or touching assistance for tub/shower transfer and walking 10 feet. He was independent with rolling left to right and sitting to lying. He required a manual wheelchair for mobility and was independent wheeling himself 50 feet with two turns. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's annual MDS assessment, dated 11/09/2024, indicated a BIMS score of 03 which indicated he was severely impaired cognitively and he was able to make himself understood and understood others. He was occasionally incontinent of bowel and bladder. The Functional self-care assessment indicated he required moderate assistance with toileting hygiene, shower/bath, lower body dressing, putting on/taking of shoes, personal hygiene, and setup or clean up assistance for eating, oral hygiene, and upper body dressing. The Functional mobility assessment indicated he required moderate assistance for sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer and walking 50 feet with two turns. He required supervision or touching assistance for walking 10 feet. He was independent with rolling left to right, sitting to lying and lying to sitting on side of bed. He required a manual wheelchair for mobility and was independent wheeling himself 50 feet with two turns. Record review of Resident #1's care plan, dated 11/09/2024, indicated he resided in the secure unit related to actual elopement attempt. No interventions on care plan prior to 11/09/2024 related to Resident #1's change in elopement risk on 11/02/2024. Care plan indicated he had an ADL self-care performance deficit and required supervision as needed for bathing, bed mobility, eating, dressing, toilet use, and transfers. Record review of Resident #1's progress note dated 10/25/2024 Resident #1 was found in the parking lot. The progress note did not address if any interventions were implemented following this incident. Record review of a quarterly Elopement Risk assessment dated [DATE] indicated Resident #1 was a high risk for elopement with a score of 16. The form was signed by LVN B. The Elopement Risk assessment did not address if any interventions were implemented following this assessment. Record review of Resident #1's progress note dated 11/04/2024 Resident #1 was found in the parking lot again. The progress note did not address if any interventions were implemented following this incident. Record review of Resident #1's event note - elope or attempt dated 11/08/2024 Resident #1 had eloped from facility out the front door and was discovered in front of the facility, resident was in his wheelchair, fully dressed, on the street heading towards the convenient store. Resident #1 was returned to the facility and was placed in the secure unit for supervision. Record review of Resident #1's physician orders dated 11/08/2024 indicated Resident #1 was moved to facility secure unit. A Provider Investigation Report dated 11/08/2024 indicated the incident occurred on 11/08/24 at 04:45 p.m. Resident #1 sits on front porch with no behaviors and no supervision. Resident goes in and out of the front door frequently throughout the day. Resident #1 was reported to the charge nurse to have been leaving the facility driveway. Resident #1 said he was going to the gas station to get scratch-offs. Resident #1 was returned to the facility by CNA A. A head-to-toe assessment was conducted with no negative findings. Resident #1 was placed in secure unit for 1:1 monitoring. Resident #1's family and physician were notified of the elopement. Physician ordered Resident #1 be placed in the secure unit and family members agreed and consented. In-services were conducted with staff on elopement protocol, on accuracy of elopement assessments, and on residents sitting out front. All residents had updated elopement assessments conducted. Resident #1 remained in the facility's secure unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Unable to interview Resident #1, he no longer resided at the facility. During an interview on 2/13/2025 7:33 a.m., LVN B said she had filled out the quarterly Elopement Risk Assessment on Resident #1 on 11/02/2024. She said she answered some of the questions based on the personal history of knowing Resident #1 and his cognitive skills, daily decision making, and behaviors and that was why it triggered him at high risk for elopement. LVN B said management staff was aware of Resident #1's high elopement risk. LVN B said the quarterly elopement risk assessment was completed to provide information for completing the quarterly MDS and updating care plan during care plan meetings if applicable. LVN B said Resident #1's family did not consent for the resident to reside on the facility secure unit until he eloped on 11/08/2024 and then they agreed with the intervention after the elopement. During an interview on 02/12/2025 at 12:20 p.m., HR C said on 11/08/2024 at approximately 4:45 p.m., she received a phone call from another resident's family member reporting Resident #1 was in his wheelchair at the end of the facility exit driveway, headed down the residential roadway. HR C said she immediately responded and notified LVN D and CNA A regarding the elopement while exiting the facility. HR C said CNA A ran down the exit driveway and residential roadway and redirected Resident #1 back to the facility. HR C said Resident #1 had a history of sitting on the front porch of the facility and greeted staff, other residents, and visitors, and she was able to monitor him from her window. HR C said she did not recall Resident #1 attempting to elope in the past but Resident #1 would ask staff and visitors to go buy him a scratch off lottery ticket occasionally when his family had not brought him any. During an interview on 02/13/2025 at 2:40 p.m., CNA A said she was working on 11/08/2024, returning from her break around 5:00 p.m. when she heard HR C said Resident #1 had eloped and was on the residential roadway headed towards the gas station. CNA A said she ran out the front door and down the roadway (approx. 50 yards from facility exit driveway) and retrieved Resident #1 and redirected him back to the facility. CNA A said Resident #1 said he was going to the gas station to buy himself a scratch-off lottery ticket. CNA A said she was not the assigned CNA working with Resident #1 on 11/08/2024 but when an elopement occurred everyone intervened. CNA A said she was familiar with Resident #1 because he moved around the facility independently in his wheelchair and would sit in the front lobby waiting for someone to disarm the alarm so he could go outside to sit on the porch. CNA A said Resident #1 would sit out on the front porch and greet visitors, staff, and other residents. CNA A said Resident #1 had been at the end of the sidewalk/parking lot area asking visitors for scratch off lottery tickets prior to the elopement but was easily redirected back into facility. CNA A said Resident #1 was allowed to sit on the facility front porch unsupervised, staff would disarm the front door, wheel him outside on porch, and frequently monitor him but would not stay outside with him. CNA A said she was not aware of any previous elopements with Resident #1 and that Resident #1 had never voiced to her about desire to leave the facility and even the day of the elopement he said he would return to the facility after he got his lottery tickets. During an interview on 02/13/2025 at 11:00 a.m., the ADON said on 11/08/2024 she had just completed her orientation and was leaving the facility when CNA A and HR C was returning to the facility with Resident #1 and was informed that Resident #1 had just eloped from the facility. The ADON said that she interviewed with Resident #1, and he said he was going to the gas station to get scratch off lottery tickets and had intentions on returning to the facility afterwards. The ADON said she notified the Administrator and Resident #1's charge nurse of the incident. The ADON said Resident #1 was placed in the facility secure unit and the charge nurse was notified of the elopement incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675620	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Nursing and Rehabilitation	1175 Denton Dr Beaumont, TX 77707

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/13/2025 at 02:18 p.m., LVN D said she was the charge nurse for Resident #1 on 11/08/2025 and around 5:00 p.m. while in the dining room for dining observations, she noticed Resident #1 being wheeled into the facility by CNA A. CNA A reported to her that Resident #1 had eloped and was on the residential roadway between the facility and the gas station and she had redirect him back to the facility. LVN D said the ADON and CNA A took Resident #1 to the facility secure unit for monitoring. LVN D said she and LVN E contacted the physician, family and completed the required assessments. LVN D said she recalled seeing Resident #1 sitting on the front porch when entering the facility to start her shift at 2:00 p.m. LVN D said all staff monitored Resident #1 and when he wanted to go outside or inside, he would ask staff to disarm the door alarms for exiting or entering the facility. LVN D said if Resident #1 was outside that staff would check on him frequently and bring him back in the facility to provided care. LVN D said she was aware that Resident #1 had been found in the parking lot asking for scratch off lottery tickets in the past but was not aware of Resident #1 ever leaving the facility premises or requesting to leave the facility prior to the elopement on 11/08/2024. During an interview on 02/13/2025 at 02:30 p.m., LVN E said she was working the secure unit on 11/08/2024, and Resident #1 was escorted to the secure unit by CNA A on 11/08/2025 around 5:00 p.m. LVN E said Resident #1 had eloped from the facility and was being placed in the secure unit for monitoring and possible permanent placement. LVN E said she and LVN D contacted the physician, family and completed the required assessments. LVN E said Resident #1 was not exit seeking while in the secure unit, he would just sit at the back door requesting someone to take him to sit outside because he liked to sit outside and enjoy the sunshine. LVN E said that staff would go outside and sit with him in the enclosed secure unit patio area. During an interview on 02/13/2025 at 02:45 p.m., the DON said that Resident #1 liked to sit on the facility front porch and greet people entering the facility. The DON said all facility staff monitored Resident #1 while he was outside. The DON could not explain how Resident #1 got off the facility premises without any facility staff being aware. The DON said she was not aware of Resident #1's high elopement risk assessment on 11/02/2024 and the assessing facility staff should have notified her or the Administrator with the high elopement assessment risk so interventions could have been initiated to prevent elopement and keep resident safe. The DON said not intervening when residents have a high elopement risk could put the residents at risk for actual elopement and lack of supervision could cause possible harm or injury to the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/13/2025 at 03:00 p.m., the Administrator said Resident #1 liked to sit on the facility front porch and greet people entering the facility. The Administrator said she was not aware of Resident #1's high elopement risk assessment on 11/02/2024 until she began investigating the elopement on 11/08/2024. The Administrator said the assessing staff member should have notified her or the DON of the high-risk elopement assessment so interventions could have been put in place. The Administrator said following the incident on 11/08/24, the staff were reeducated on elopement, accuracy of elopement assessments, reporting residents with high elopement assessments to the DON and/or the Administrator; management reassessed all residents for elopement risk; the elopement log was updated; and elopement drills were being conducted randomly. She said the elopement attempt was included in the QAPI report. The Administrator said all door alarms were checked the day of the elopement and was found to be working properly. The Administrator said residents were allowed to be outside unsupervised if their elopement risk assessment was low and the safety assessment indicated it was safe for them to be left alone. The Administrator said facility staff developed an individualized plan for each resident to meet their needs and maintain the least restrictive environment. The Administrator said it was common for Resident #1 to be sitting out on the front porch and she was not sure if staff had let him out on the day of the elopement or if Resident #1 had followed a family member out the door when they were exiting. The Administrator said Resident #1 was redirected back to the facility within a few minutes of the facility being aware Resident #1 was off the facility premises. The Administrator said once Resident #1 was back in the facility, a head-to-toe assessment was completed with no injuries identified, the physician and family were notified, and orders were received for Resident #1 to be placed in the secure unit. The Administrator said Resident #1 was placed in the secure unit and monitored following the elopement. The Administrator said if a resident was identified as a high risk for elopement, the assessing nurse or staff should notify her and the DON so interventions could be put in place to prevent elopement and keep the resident safe. The Administrator said if she or the DON were not notified of the high elopement risk and interventions did not get initiated, it could put the residents at risk for actual elopement and lack of supervision could cause possible harm or injury to the resident. Record review of the Elopement Prevention policy dated January 2023 indicated .1. The elopement risk assessments will be completed upon admission the assessment should be completed by reviewing the residents medical history and social history information may be obtained by reviewing current medical records if available interview with residents family or conference with the interdisciplinary team members the assessment tool should be completed and interventions implemented as indicated the elopement risk assessment is to be completed at least quarterly, after an elopement attempt, upon new exit seeking behaviors, and upon change of condition. Record review of an In-Service Attendance Record with subject of Elopement Response and prevention, dated 11/08/2024, indicated that 49 staff members signed the in-service record including CNA A, LVN B, HR C, LVN D and LVN E. Record review of Assessment History Elopement Risk Assessment list dated 02/11/2025 at 09:54 a.m. indicated all residents in the facility were reassessed on 11/09/2024. Record review of Incident logs from 02/01/2024 through 02/11/2025 indicated there were no other actual resident elopements from the facility. Record review of the Elopement Risk Assessment Log on 02/11/2025 indicated it was updated to include current residents assessed as high risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During observations on 02/11/2025 from 09:00 a.m. - 02/13/2025 to 5:30 p.m., of current residents at risk for elopement indicated staff-maintained residents within eye contact and staff did not allow them to go outside of the facility without a staff member with them and/or the resident resided in the facility secure unit. During interviews on 02/11/2025 from 09:00 a.m. - 02/13/2025 to 5:30 p.m., 1 RN (RN N), and 4 LVN's (LVN B, LVN D, LVN E, and LVN O) were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure, all were aware of the new expectations to notify the DON/ADON and the Administrator immediately of any assessments identifying a resident with a high elopement risk and/or residents exit seeking, attempting or actual elopement. During interviews on 02/11/2025 from 09:00 a.m. - 02/13/2025 to 5:30 p.m., 7 CNA's (CNA A, CNA F, CNA G, CNA H, CNA I, CNA J, and CNA L), and 1 MA (MA K) were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure, all aware of residents requiring supervision if outside, and all were aware to notify the CN, DON, ADON and the Administrator immediately of any residents exit seeking, attempting or actual elopement. During interviews on 02/11/2025 from 09:00 a.m. - 02/13/2025 to 5:30 p.m., 1 Human Resource staff (HR C), 1 MDS Nurse (MDS M), Floor Tech (FT P), 1 Housekeeping staff (HSK Q), Business office staff (BO R) and maintenance staff (MT S) were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure, they were aware of the new expectations to notify CN, DON, ADON before allowing any resident outside alone, and to notify the DON/ADON and the Administrator immediately of any resident trying to go outside alone. On 02/13/2025 at 05:45 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 11/02/2024 and ended on 11/08/2024. The facility had corrected the noncompliance before survey began.