

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER Sabine Heights Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 Ninth Ave Port Arthur, TX 77642	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for two (Resident #1 and Resident #2) of two residents reviewed for quality of care. The facility failed to transfer Resident #1 safely and appropriately, leaving her armpit, arm, and chest area bruised. The facility failed to transfer Resident #2 safely when they failed to ensure the gait belt was not too loose to use appropriately and lifted the resident mostly under her armpits when transferring her from the bed to the wheelchair on 05/01/26. This failure could affect the residents by placing the residents at risk for discomfort, pain, and/or injury. Findings included: 1. Record review of Resident #1's face sheet, dated 05/01/26, reflected an admission date of 11/04/25. Resident #1's active diagnoses included iron deficiency anemia (blood disorder defined by low hemoglobin level caused by insufficient iron, resulting in reduced oxygen delivery to body tissues), muscle weakness, lack of coordination, and muscle wasting and atrophy (loss of muscle tissue, resulting in decreased muscle size and strength). Record review of Resident #1's quarterly MDS assessment, dated 02/05/26, reflected a BIMS summary score of 09, which indicated moderate cognitive impairment. The functional abilities section under mobility for sit to stand reflected 02, which indicated substantial/maximal assistance - helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort. Record review of Resident #1's ADL care plan, initiated 11/12/21, reflected .[Resident #1] has an ADL self-care performance deficit r/t impaired balance and Chronic bilateral (both sides) knee pain secondary to osteoarthritis (degenerative joint disease) . Record review of Resident #1's skin related incident report, dated 04/24/26, reflected .Nurse was called to the resident?s (sic) room by CNA. Upon assessment, the resident was noted to have bruising to the right upper arm and right upper chest area. The resident complained of pain in the affected areas. The resident stated that the bruising occurred after being transferred from bed to wheelchair. When they moved me to my w/c yesterday it got there.bruise.right shoulder (front). Record review of Resident #1's weekly skin review/assessment, dated 04/24/26, reflected .site 6) right shoulder (front). res has bruising on the right shoulder. Record review of Resident #1's head to toe skin check, dated 04/29/26, reflected .intact skin.existing bruise (s). Resident has bruising to right upper arm and right upper chest that is starting to fade.12) Chest.15) Right antecubital (transition zone between the arm and forearm) . During an interview with Resident #1 on 05/01/26 at 09:26 a.m., she stated she was always assisted by two people. She stated she had bruising and revealed a deep purple bruise under her armpit extending to her bicep that covered most of her bicep. She stated the bruising extended to her chest and down her side. She was unable to give an exact date of the incident, but said two people assisted her from her bed to her wheelchair by holding her under her arms. She stated, I got bruised.yes it hurt.my arm is bruised. She was unable to recall which staff assisted her. 2. Record review of Resident #2's face sheet, dated 05/04/26, reflected an admission date of 04/11/26. Resident #1's active diagnoses included displaced fracture on right foot, muscle weakness, lack of coordination, and hemiplegia and hemiparesis following a stroke affecting the left side (paralysis and weakness on one side). Record review of Resident #2's quarterly MDS assessment, dated 04/16/26, reflected a BIMS (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	summary score of 12, which indicated moderate cognitive impairment. The section for mobility devices included use of a walker and wheelchair. Record review of Resident #2's ADL care plan, initiated 04/21/26, reflected . The resident has an ADL self-careperformance deficit r/t FRACTURE OF UNSPECIFIED METATARSAL BONE(S) (bone in the midfoot that connects ankle to toes), RIGHT FOOT, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH DELAYED HEALING. During an observation on 05/01/26 at 09:35 a.m., CNA A and CNA B were assisting Resident #2 to her wheelchair. The wheelchair was tilted facing the bed and the wheels were locked. There was a gait belt around the resident. When the two CNAs grabbed the gait belt, it was way too loose as evidenced by a huge gap when they attempted to hold it. It was loose enough; it went up to the armpit immediately. There was a CNA on each side of the resident, holding under each armpit and the resident was pivoted into the wheelchair. There were no signs of pain or other issues seen from Resident #2. The transfer was completed, successfully. During an interview on 05/01/26 at 9:38 a.m. with CNA A, she stated she had received training on transfers. CNA A stated gait belts were to be used on all transfers. She stated two fingers should be able to fit under the gait belt. The gait belt should not be too loose or too tight. She stated the gait belt was not tight enough during the observed transfer. She stated improper transfers could cause a fall, bruising, or possibly a shoulder dislocation. During an interview on 05/01/26 at 9:47 a.m. with CNA B, she stated she had received training on transfers. CNA A stated gait belts were to be used on all transfers. She stated two fingers should be able to fit under the gait belt. The gait belt should not be too loose or too tight and should be around the midsection or abdomen area. She stated most of the weight during the transfer was on Resident #2's underarms. She stated improper transfers could cause bruising, or a skin tear. During an interview on 05/01/26 at 11:53 a.m. with CNA A, she stated she worked the day the facility thought the bruising happened with Resident #1. She stated she transferred the resident twice that day with another CNA. She stated she always used a gait belt. She said she had no idea Resident #1 was hurt that day. She never saw any bruising that day, and Resident #1 did not say anything to her that day about pain in her arm. During an interview on 05/01/26 at 11:57 a.m. with PT C, he stated the protocol was to use gait belts during transfers. PT C stated, staff must be careful when using the gait belt, it can put too much stress on the upper body and chest area of the resident and could cause dislocation. The gait belt should be placed at the waist area, and one hand should fit under the gait belt. The gait belt should not be too loose or too tight. There should be one hand at the belt and one at the arm, and most of the weight should be supported by the gait belt. PT C stated improper placement of the belt could cause bruising or more. During an interview on 05/01/26 at 01:18 p.m., the DON stated the gait belt was not put on tight enough for Resident #2's transfer. He stated CNA A and CAN B were probably nervous. He stated the gait belt should be on the lower waist and fit only a couple fingers underneath to not cut off circulation but also should not have slack either. He stated during the observed transfer, the gait belt was loose and once Resident #2 stood up, the gait belt served no purpose. The DON stated Resident #1 was anemic, and that could be the reason for the extensive bruising. The DON stated improper transfers could cause a fall, bruising, or pulling of the skin. The DON stated in-services were initiated for all staff regarding transfers after Resident #1's bruising was found. Review of the facility in-service, CNA - Safely Moving Residents - Lifting and Transferring, assigned 04/28/26, indicated CNA A completed the in-service on 04/28/26 and CNA B had completed the in-service on 04/29/26. Review of the facility's policy, Safe Lifting and Movement Residents, revised July 2017, reflected, .the facility uses appropriate techniques and devices to lift and move residents.5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary.		