

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Seabreeze Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6602 Memorial Dr Texas City, TX 77590	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. Food items were observed stored in the facility refrigerator without proper sealing. This failure could place residents who received meals from the main kitchen at risk for food borne illness. Findings included: Observation on 1/6/2026 at 8:32 am revealed one 1-gallon full container of ranch dressing with visible food residue and buildup on the exterior surfaces including the lids and surrounding container. Observation on 1/6/2026 at 8:33 am revealed one 1-gallon full container of soy sauce with buildup on the exterior surfaces including surrounding container. In an interview with The Dietary Manager on 1/7/2026 at 3:40 pm. She said it was important to wipe each container completely after use to ensure the date was clearly visible on each container. She said it was her responsibility to ensure food items were cleaned, dated, and labeled. She said all kitchen staff were responsible for labeling, dating, storing, and cleaning all items. She acknowledged the containers appeared unclean. She said the condition of the containers could place residents at risk of potential illness. In an interview with The [NAME] President of Clinical services on 1/8/2026 at 3:08 pm. She said the food server supervisor, dietician and the administrator do rounds in the kitchen. She said the condition of the containers could place residents at risk of potential illness. Record review of the facility's Food Safety Requirements dated 7/23/25 under Policy Explanation and Compliance Guidelines read in part. 1b. Store food in a manner that prevents deterioration or contamination of the food.		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure, when a discharge was anticipated, to complete a discharge summary, including but not limited to, a recapitulation of stay, a reconciliation of pre-discharge medications, a final summary of the residents' status, and post-discharge plan of care Based on observation, interview and record review, the facility failed to ensure, when a discharge was anticipated for 1 of 3 residents reviewed for discharge summary (Resident # 60). --the facility failed to complete a discharge summary for Resident #60. This failure could place residents at risk of incomplete discharge records. Findings include: Record review of Resident #60's face sheet revealed admission date 7/15/25 with diagnoses including cerebral infarction (disruption of blood flow to brain), carotid artery syndrome (plaques clog blood vessels that deliver blood to the brain), Meniere's disease (inner ear disease), heart disease (conditions affecting the heart and blood vessels), Parkinsonism (neurological condition causing movement-related symptoms), muscle wasting and atrophy loss of muscle tissue), and discharge date [DATE]. Record review of Resident # 60's Discharge MDS dated [DATE] revealed discharge, return not anticipated; planned discharge; discharge to nursing home; BIMS 15 indicating no cognitive deficits; functional ability on discharge: eating-independent, oral hygiene-set up, toileting hygiene-maximum assistance, shower/bathing-maximum assistance, upper body dressing-set up, lower body dressing-maximum assistance, personal hygiene-maximum assistance; catheter due to neurogenic bladder; occasionally incontinent of bowel. Record review of Resident # 60's progress note dated 11/12/25 revealed discharge to another facility today, which was the plan upon admission. All belongings, medications, face sheet sent with resident. Emailed Ombudsman of discharge. In an interview with the VP Clinical Services on 1/13/26 at 3:30 pm, she said the company policy is to complete a Recapitulation of Stay Summary form for all discharges, which includes final diagnosis, brief history, pertinent physical and laboratory findings, course of treatment, condition on discharge, rehabilitation potential, and follow-up and discharge medication instructions. She said the discharge summary for Resident # 60 was not completed due to changes in administrative staff, which caused lack of availability of staff to complete it. She said she has done an in-service with ADON on the Recapitulation of Stay Summary, and she will complete it for discharged residents going forward. She said the risk of not having a discharge summary would be incomplete resident information for the next facility. In an interview with ADON on 1/14/26 at 10:20am, she said she did have an in-service on the discharge summary form, and she will complete it for discharges. She said the risk of not having a discharge summary would be not having accurate discharge information. In an interview with the MDS nurse on 1/14/26 at 12:30pm, she said she completes the Discharge MDS, but she does not complete the discharge documents. She said Resident # 60 came here with plans to go to a place closer to home. Record review of the facility Discharge Summary policy read, in part: a discharge summary is provided upon a resident's discharge which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screenings for 1 of 5 residents (Resident #44) reviewed for PASRR. The facility failed to ensure that Resident #44's PASRR screening was updated accurately as evidenced by Form 1012 not being completed and submitted in a timely manner. These failures could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of Resident #44's face sheet dated 1/8/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including unspecified dementia (group of symptoms affecting memory, thinking and social abilities), unspecified severity, with mood disturbance. Record review of Resident #44's quarterly MDS dated [DATE], section C revealed a BIMS score of 11 that indicated cognition was intact. Section I revealed active diagnoses of non-Alzheimer's dementia (group of symptoms affecting memory, thinking and social abilities), anxiety disorder, depression and psychotic disorder with additional active diagnoses of unspecified dementia, unspecified severity, with mood disturbance; anxiety disorder, unspecified; and other schizoaffective disorders. Record review of Resident #44's Continuity of Care Document dated 1/8/26 revealed problems of unspecified dementia (group of symptoms affecting memory, thinking and social abilities), unspecified severity, with mood disturbance with effective date 7/16/24; dementia (group of symptoms affecting memory, thinking and social abilities) in other diseases classified elsewhere, unspecified with effective date 7/16/24; anxiety disorder, unspecified with effective date of 12/1/25; generalized anxiety disorder with effective date 5/15/24; other specified mental disorders due to known physiological condition with effective date 2/7/24; dementia (group of symptoms affecting memory, thinking and social abilities) in other diseases classified elsewhere, unspecified with effective date 8/16/23; other schizoaffective disorders (disorder with abnormal thought processes and an unstable mood) with effective date 6/16/23; anxiety disorder due to known physiological condition with effective date 6/16/23 and depression, unspecified with effective date of 6/16/23. Record review of Resident #44's care plan revealed problems of taking antipsychotic for depression with start date of 7/3/25, taking antipsychotic for schizoaffective disorder with start date of 7/3/25, cognitive loss/dementia with start date of 6/16/23 and schizoaffective disorder with use of Amitriptyline and Ritalin with start date of 6/16/23. Record review of Resident #44's physician's orders as of 1/8/25 revealed order for psychiatric and psychological services to evaluate and treat as needed with start date of 6/16/23. Record review of Resident #44's SNF History and Physical dated 8/7/2025 revealed past medical history of bipolar disorder (mental illness associated with episodes of mood swings ranging from extreme sadness or excitement) and schizophrenia (chronic mental disorder that affects how a person thinks, feels and behaves). Record review of Resident #44's PASRR Level 1 Screening with date of screening of 3/30/2024 revealed no evidence that dementia was the primary diagnosis and no evidence of mental illness. Record review of Resident #44's Form 1012 revealed PASRR level 1 date of assessment of 3/30/2024 with schizoaffective disorder marked yes under mental illness indication completed by the Clinical Care Manager. Under section D (Nursing Facility Action) it was indicated that a new positive PL1 was submitted but no date was indicated and no signature date under section E (Staff Completing Form). During interview on 1/8/26 at 11:00 a.m., the Clinical Care Manager said regarding PASRR that a resident had to have a mental illness diagnosis prior to a certain age to be answered yes under Section C on PASRR Level 1 Screening form, but she was going to contact someone from corporate to follow up. During interview on 1/8/26 at 11:35 a.m., the Clinical Care Manager said she had a stack of residents that she had been reviewing, and Resident #44 was one. The Clinical Care Manager said she could only send 3-4 PASRR (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	referrals at a time. The Clinical Care Manger said she was in the process of sending a Form 1012 for Resident #44 and he was there a year before she started at the facility. The Clinical Care Manager said Resident #44 would be reevaluated when the referral was received. During interview on 1/8/26 at 11:40 a.m. the ADON said the Clinical Care Manager was responsible for making sure the PASSR came with the resident and was correct and getting completed if the PASSR was not completed. The ADON said she did not deal with the PASSR and could not explain how it would affect the residents if it was not accurately completed and said to ask the Clinical Care Manager as she was the one who deals with the PASSRs. During interview on 1/8/26 at 2:50 p.m., the Clinical Care Manager said if the PASRR was not completed correctly the effect it could have on the residents was that if it was supposed to be positive then they could miss out on PASRR services. The Clinical Care Manager said the #1012 form was how they rectified that and she did an audit of the residents. The Clinical Care Manager said if you see something suspicious you complete the #1012 form to see if the resident qualifies for services. During interview on 1/8/26 at 3:01 p.m., the [NAME] President of Clinical Services saidThe Clinical Care manager was responsible for PASRRs and was responsible for sending in the updated forms. The [NAME] President of Clinical Services said prior to 10/1/25 there was a corporate PASRR person who did the PASRRs for all of the facility and effective 10/1/25 there was no longer a corporate PASRR person, and the facilities had to do the PASRRs. The [NAME] President of Clinical Services said residents could possibly not get the services they were entitled through PASRR if PASRRs were not completed correctly. Record review of the facility's policy titled Preadmission Screening and Resident Review (PASRR) revised 2/1/2023 revealed The facility must use the Mental Illness/Dementia Resident Review form (Form 1012) for assistance in determining whether a resident needs further evaluation if a resident currently has a negative PL1 and is suspected to have or is diagnosed with a mental illness. A. The CCM must ensure that the 1012 form is completed and uploaded into the resident's electronic medical record.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care or 1 or 1 resident (Resident #57) reviewed. The facility failed to complete the baseline care plan within the required 48-hour timeframe following admission for Resident #57. This failure could place the residents at risk for unmet care needs due to inconsistent care, or failure to receive required services. Findings included: Record review of Resident #57's electronic admission record undated revealed she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included Malignant neoplasm of right main bronchus (cancer located in the right main bronchus, which is one of the large airways that carries air from the trachea into the right lung), adult failure to thrive, pressure ulcer of sacral region, unstageable(pressure injury cannot be assigned a stage because the base of the wound is not visible). Record review of Resident#57 revealed no baseline care plan was developed upon admission. Record review of Resident #57's primary physician record dated 12/19/2025 revealed she was admitted to a hospice agency with a diagnosis of lung cancer and a code status of DNR (Do not resuscitate). In an interview on 01/08/2026 at 3:08 PM The Regional Nurse said the facility policy requires baseline care plan completion within 48 hours. She said the Director of Nursing and the Assistant Director of Nursing was responsible for the completion of the baseline care plan. She said the baseline care plan for Resident # 57 was not completed. She said the risk to the residents could lead to potential illness. In an interview on 01/08/2026 at 3:23 PM the Assistant Director of Nursing said she could not explain why the baseline care plan was not completed withing 48 hours of resident admission. She said the Director of Nursing was responsible for completing the baseline care plan. She said the baseline care plan for Resident # 57 was not completed. She said not having the baseline care plan completed the risk could lead to a negative outcome for both residents. Record Review of the facility policy subject titled, Baseline Care Plan date implemented 07/2025, revealed policy statement The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1.The baseline care plan will:a. Be developed within 48 hours of residents' admission. b. Include the minimal healthcare information necessary to properly care for a resident including but not limited to: Initial goals based on admission orders. Physician orders . Dietary orders . Therapy services . social services .Preadmission Screening and Resident Review recommendations if applicable.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team for 1 (Resident #61) of 5 residents reviewed for care plan. The facility failed to ensure that Resident #61's care plan was reviewed and revised regarding her weight changes and reflected both weight gains and losses. This failure could place residents at risk of not being able to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings included: Record review of Resident #61's face sheet dated 1/8/25, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including other encephalopathy (any condition that disrupts the normal functioning of the brain). Record review of Resident #61's quarterly MDS dated [DATE], section C revealed a BIMS score of 13 that indicated cognition was intact (13-15). No weight loss or weight gain of 5% or more in the last month or loss of 10% or more in the last 6 months was documented under section K. Record review of Resident #61's care plan as of 1/7/2026 revealed problem of Resident has experienced weight gain R/T 5/7/24 Weight 232lbs Gain 7.4% (16lbs) in 30 days, 8.2% (17lbs) in 90 days. with problem start date of 5/13/2024 and last reviewed/revised date of 1/6/26. Another problem of I have experienced a significant weight loss within the past 30 days. I am at risk for a significant weight loss, the following conditions contribute to my weight loss and risk comorbidities. with problem start date of 10/24/2023 and last reviewed/revised date of 1/6/2026. Record review revealed progress note by the Registered Dietician on 9/9/2025 at 2:04 p.m. that Resident #61 had a weight loss of 1.4% in the last 30 days, weight gain of 4.2% in the last 90 days and weight gain of 14.5% in the last 180 days. Progress note dated 9/9/2025 at 2:04 p.m. also revealed potential shifts in weight due to diuretic treatment with recent adjustment made could be expected. Record review of Resident #61's weights revealed a weight of 297.2 pounds on 1/6/2026, weight of 310.6 pounds on 10/7/2026 and weight of 312.5 pounds on 7/8/2025. During interview on 1/8/26 at 11:00 a.m., the Clinical Care Manager said if there was something acute like a fall or a skin tear then nursing would update the care plan. The Clinical Care Manager said weight issues on the care plan would be completed by the ADON as she was over weights. During interview on 1/8/26 at 11:40 a.m. the ADON said if it was something specific like weights, then she (the ADON) would be responsible for making changes to the care plans. The ADON said Resident #61 had weight changes due to fluid changes and had gone to the hospital to be diuresed (given medications to have excess fluid removed from the body). The ADON said the care plan entry that said, I have experienced a significant weight loss within the past 30 days. I am at risk for a significant weight loss should just be the resident is at risk of weight loss. The ADON said the weight gain was specific and would check if that would have been resolved since it was from 2024 and updated new weights. The ADON said she would not have changed these sections on the care plan unless Resident #61 had triggered for her. The ADON said if care plans were not updated then residents' care was not specific to them and care plans should be updated to their needs and wants. The ADON said the DON was terminated 1/7/2026. During interview on 1/8/26 at 3:01 p.m., the [NAME] President of Clinical Services said the DON, ADON and CCM were the three people responsible for updating care plans. The [NAME] President of Clinical Services said the DON or ADON was responsible for updating the acute care plans. The [NAME] President of Clinical Services said if the care plans were not updated the residents might not get the level of care they should, and the nursing staff might not know that anything had changed regarding residents' care. The [NAME] President of Clinical Services said the DON should be checking the care plans for accuracy. Record review of facility's policy Comprehensive Care Plans with date implemented 7/2025 revealed The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.		