STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676484	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mont Belvieu Rehabilitation & Healthcare Center	14000 Lakes of Champions Blvd Mont Belvieu, TX 77523

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 8 residents (Resident #1) reviewed for resident records. The facility failed to ensure LVN A documented Resident #1's change of condition, physician notification, and transport to hospital on 09/30/24. This failure could place residents at risk for delayed care and appropriate interventions. Findings included: Record review of Resident #1's face sheet dated 09/20/24 indicated he was a [AGE] year old male, admitted on [DATE] and his diagnoses included acute respiratory failure with hypoxia (impaired gas exchange between lungs and blood resulting in low oxygen levels in body tissues). Record review of Resident #1 physician orders dated 8/29/24 indicated Resident #1 was on enteral feed (feeding through G-tube) and he was administered medications via G-tube (feeding tube) for SOB, infection, dementia (gradual decline in cognitive abilities that interferes with daily life), and HTN (high blood pressure). Record review of Resident #1's discharge MDS dated [DATE] indicated Resident #1 was discharged with return anticipated. Record review of Resident #1's care plan dated 08/30/24 the facility would provide Resident #1 and his representative a summary of the base line care plan within 48 hours. Resident #1 had the following special treatments/needs: for treatment included IV medications, hospice care, tracheostomy (opening in the neck into the windpipe/trachea to allow air to flow into the lungs), suction, oxygen, CPAP (a machine that sues mild air pressure to keep breathing airways open while sleeping), isolation, wound vac (a treatment that uses a suction pump and dressing to help heal wounds), dialysis, diabetic care, and pressure ulcers. Record review of a progress note dated 08/30/24 at 8:39 a.m., completed by LVN A indicated Resident #1 was hospitalized . There was no documentation of Resident #1's change of condition, vital signs, physician notification, treatment or care provided, or that he was transported to hospital for evaluation and treatment. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's hospital records dated 08/30/24 indicated Resident #1 admitting diagnoses included hypertension, low O2 sats and his diagnoses included Parkinson's (brain disorder that affects movement and mental health) and Alzheimer's dementia (brain disorder that gradually destroys memory and thinking skills). Record review of a text message dated 08/30/24 sent to MD D by LVN A indicated Resident #1 was sent to (named hospital) for hypoxia and tachycardia. O2 was 70 and hr was 118. O2 15 L applied. O2 84. Record review of a text message dated 08/30/24 indicated MD D responded OK to LVN A's text message. During an interview on 09/20/24 at 12:31 p.m., CNA B said she checked on Resident #1 between 6:00 a.m. and 7:30 a.m. on 08/30/24. She said Resident #1 was on his right side facing the doorway of his room. She said she continued on her rounds and started passing breakfast trays. CNA B said she heard Resident #1's daughter calling for help at approximately 7:30 a.m. She said Resident #1's daughter said he had vomited and was spitting out of his mouth. She said she went into Resident #1's room and observed Resident #1 had vomited. She said she reported Resident #1 had vomited to LVN A. She said LVN A checked for Resident #1's code and then called code and all the nurses arrived at Resident #1's room with the crash carts. She said she left the room to continue care of the other residents. During an interview on 09/20/24 at 12:59 p.m., CMA C said she administered Resident #1's eye drops at 7:00 a.m. on 08/30/24 and then went into another resident's room. She said she heard Resident #1's daughter was calling for help because Resident #1 had vomited. During an interview on 09/20/24 at 11:50 a.m., the DON said he became aware on 09/20/24 that LVN A had not documented Resident #1's change of condition or transport to hospital in the EMR on 08/30/24. He said it was his expectation all staff completed documentation prior to end of shift. He said residents were at risk for delayed care if the proper documentation was not completed. During an interview on 09/20/24 at 1:19 p.m., LVN A said it was hectic on 08/30/24 when Resident #1 had vomited and required transport to the hospital due to change of condition. He said the physician was notified by secure message he (LVN A) was sending Resident #1 to the hospital and the doctor responded ok via the secure message system. He said he said he forgot about documenting Resident #1's change of condition in Resident #1's chart. He said he was aware he should have documented Resident #1's change of condition, physician communication, and transport to hospital in Resident #1's EMR. Record review of the facility's policy Charting and Documentation policy dated 2001 (revised July 2017) indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. 2. The following information is to be documented in the resident medical record: a. Objective observations; 2. Medications administered, Treatments or services performed: d. Changed in the resident's condition; Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives.7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided care; c. the assessment data and .or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting.