

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879</b></p> <p>Based on interviews, observations, and record reviews, the facility failed to ensure the residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, which includes but not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms for 2 (Resident #1 and Resident #2) of 10 residents reviewed for involuntary seclusion.</p> <p>The facility failed to ensure CNA A did not place gloves in the Resident #1 and Resident #2 door to keep Resident #2 from wandering outside her room on 06/21/2024.</p> <p>The non-compliance was identified as past non-compliance. The noncompliance began on 06/21/2024 and ended on 06/21/2024. The facility had corrected the non-compliance before the survey began.</p> <p>This failure could place residents at risk of feeling isolated, fearful, hopelessness uncomfortable, disrespected, decreased self-esteem, and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's Admission Record dated 12/09/2024 indicated she was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which including diverticulitis (a gastrointestinal disease that occurs when pouches in the large intestine wall become inflamed or infected), muscle weakness, abnormal gait and mobility, protein malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), macular degeneration (a disease that causes central vision loss), and depression (mental illness that negatively affects how you feel, the way you think and how you act).</p> <p>Record review of Resident #1's admission MDS assessment, dated 05/13/2024, indicated a BIMS score of 15 which indicated she was cognitively intact and was able to make herself understood and understood others. She was continent of bowel and bladder. Functional Status reflected she required supervision or partial assistance with her ADLs except eating. Resident #1's Mobility Assessment reflected she required supervision or partial assistance with transfers and ambulation.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan, dated 05/15/2024, indicated she required limited assistance by staff to move between surfaces and required a rollator walker when ambulating. She was an active participant in structured activities and to encourage resident to participate in activities of choice and respect resident's right to refuse activities that are not desired.</p> <p>Record review of Resident #2's Admission Record dated 12/09/2024 indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fracture of left pubis (a break in the pelvic bone), muscle weakness, abnormalities of gait, dementia (loss of cognitive functioning) and depression (mental illness that negatively affects how you feel, the way you think and how you act).</p> <p>Record review of Resident #2's admission MDS, dated [DATE], indicated a BIMS score of 2 which indicated she was severely cognitively impaired and was able to make herself understood and understood others. She was always incontinent of bowel and bladder. Functional Status reflected she required moderate to maximum assistance with her ADLs except eating. Resident #1's Mobility Assessment reflected she required moderate to maximum assistance with transfers and did not ambulate used wheelchair for mobility.</p> <p>Record review of Resident #2's care plan, dated 07/06/2024, indicated she was an elopement risk/wanderer disoriented to place, had a history of attempts to leave facility unattended, had impaired safety awareness, and wandered aimlessly. She had interventions for staff to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. She had interventions for staff to identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.</p> <p>Record review of the provider investigation report indicated incident category: neglect, and incident date 06/21/2024, description of allegation: CNA B reported that she went to answer a call light for Resident #1 and Resident #2 and noticed gloves had been shoved in the door frame keeping the door from opening. Provider Response: Administrator and DON immediately started to review cameras to see who placed gloves in the door frame. Local police department was notified. Head to toe assessments were done on resident's, families were notified, and Social Worker interviewed both residents to ensure they were ok, and both were fine and felt safe. Investigation Summary: After reviewing camera footage, it was found that CNA A had placed gloves in the door frame to keep it from opening. She was immediately suspended pending an investigation. DON spoke with CNA A later in the day, and she confirmed that she did put gloves in the door frame. Provider Action Taken Post-investigation: CNA A stated that she put gloves in the door frame to keep Resident #2 from wandering out of the room. CNA A was terminated. An in service was conducted on abuse and neglect. The Social Worker interviewed other residents, and everyone was ok and had no issues.</p> <p>Record Review of Resident #1 Skin assessment dated [DATE] indicated no skin abnormalities.</p> <p>Record Review of Resident #2 Skin assessment dated [DATE] indicated no skin abnormalities.</p> <p>Record review of the statement by Social Worker C (dated/undated) indicated she spoke with Resident #1 and Resident #2's responsible party following the incident and Resident #1 felt safe at the facility and was observed continuing her daily activities with no distress. Resident #2's responsible party was thankful for the information.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/09/2024 at 4:34 p.m. with CNA B, she said that when she arrived to work on 06/21/2024 at 6:00 a.m., shortly after report around 6:15 to 6:30 a.m., Resident #1's call light came on and she went to answer it. She stated when she arrived at the door entering Resident #1's room it would not open, and she noticed gloves shoved in the door frame above the door handle keeping the door from opening easily. She said she heard Resident #1 on the other side of the door saying she could not open the door that was why she pushed her call light; she was trying to get out of room to go have her morning coffee. She told Resident #1 to stand away for door and she pushed on the door with body/hip forcefully and the door came open. CNA B said she removed the gloves from the door frame and assisted Resident #1 out of the room to get her morning coffee and immediately went to the DON and reported the incident. CNA B said that Resident #1 was a little concerned when she could not get the door open, but once the door was opened and she got her morning coffee, she seemed fine, no signs of distress. CNA B said she returned to the room to check on Resident #2 and she remained in her bed unaware that the event had occurred. CNA B said she called CNA A and ask her about the gloves in the door and she said she had done that to keep Resident #2 from wandering. CNA B said she was told by CNA A that she had placed the gloves in the door frame around 5:30 a.m., while she was providing care to another resident to prevent Resident #1 from wandering out of her room while she was behind a closed door assisting another resident. CNA B said she removed the gloves and opened the door around 6:30 a.m.</p> <p>In an interview on 12/09/2024 at 4:51 p.m. with CNA A, she said on 06/21/2024 around 5:30 a.m. a call light came on for Hall 700, a resident requesting to be changed. While she was in the hallway getting supplies, she noticed Resident #2 was up wandering in the hallway, so she took Resident #2 back to her room and placed her in bed. When she exited the resident's room, she placed gloves in the door frame to keep the door closed so that Resident #2 could not be wandering in the hallway or possibly go outside while she was behind a closed door changing another resident. CNA A said at the time I thought I was protecting [Resident #2], since I was behind a closed door and could not monitor her. My coworker had left early that morning for clinicals, so I was trying to make sure she did not leave her room and wander away while I was occupied with another resident. I was going to go back and remove the gloves when I finished care on the other resident, but I forgot. CNA said when she finished providing care to the other resident she went and took the soiled trash outside to the dumpster and when she entered the facility, the oncoming staff were in the building. CNA A said, at the time I thought I was protecting the resident, but I now understand that was wrong and not to do that again. I was terminated because of the incident. CNA A denied using this technique in the past to keep residents in their room.</p> <p>In an interview on 12/10/2024 at 9:00 a.m. with the ADON, she said when management was notified of the incident regarding Resident #1 and Resident #2 door, she immediately provided a head-to-toe assessment of Resident #1 and Resident #2 with no injuries or distress observed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/2024 at 9:45 a.m. with the DON, he said that he was notified of the incident with Resident #1 and Resident #2's door being hard to open because of gloves in the door frame on 06/21/2024 around 6:30 a.m. The DON said that they immediately started investigating the incident, ADON provided head to toe assessment of both residents, started watching cameras to identify who had placed the gloves in the door frame and interviewing involved staff. The DON said that CNA A admitted that she placed the gloves in the door frame of Resident #1 and Resident #2's door, to keep Resident #2 in her room while she provided care for another resident. The DON said CNA A said she thought she was protecting Resident #2 from wandering out of the room while she was behind a closed door changing another resident. The DON said CNA A was suspended during the investigation and later terminated. The DON said the [NAME] footage confirmed that CNA A was the staff that placed the gloves in the door frame of Resident #1 and Resident #2's room.</p> <p>In an interview on 12/10/2024 at 2:15 p.m. with the Administrator, he said he assisted in investigating the incident with Resident #1 and Resident #2's door being hard to open because of gloves in the door frame. The administrator said that he watched camera footage and interviewed involved staff and found that CNA A had placed the gloves in the door frame to keep Resident #2 from wandering out of her room while she was providing care to another resident. The Administrator said that the camera footage confirmed that CNA A placed the gloves in the door frame and that CNA A admitted, during an interview, that she placed the gloves in the door frame and thought she was protecting the resident. The Administrator said CNA A was suspended during the investigation and was later terminated due to the confirmation of abuse/neglect allegation. The administrator said the incident was also reported to the local police department. The Administrator said the residents involved were assessed with no injuries or distress noted, safe surveys provided by social worker with no negative outcomes, families and MD were notified of incident. The Administrator said staff were in-serviced regarding abuse and neglect. The Administrator said that the incident was reported to the State Agency as a neglect incident because he was unaware of what category the incident would fall under. The Administrator said his expectations were that the facility remains free of any resident abuse, neglect, and involuntary seclusion.</p> <p>.During observations on 12/09/2024 from 9:15 a.m. - 12/10/2024 4:00 p.m., on Hall 100, 200, 300, 500, 600, and 700 of sampled residents with wandering risk indicated staff closed doors only upon the request of the residents, for privacy during care and no resident seclusion observed.</p> <p>During interviews on 12/09/2024 from 9:15 a.m. - 12/10/2024 4:00 p.m., 1 RN had received training on resident rights, abuse, neglect including involuntary seclusion and was able to identify resident's rights, was knowledgeable that residents have the right to wander and that residents cannot be placed in a room with closed/obstructed door alone for prevention of wandering, was aware to notify the DON/ADON and the Administrator immediately of any resident involuntary seclusion.</p> <p>During interviews on 12/09/2024 from 09:15 a.m. - 12/10/2024 4:00 p.m., 4 LVNs had received training on resident rights, abuse, neglect including involuntary seclusion and were able to identify resident's rights, all were knowledgeable of the abuse, neglect, and involuntary seclusion policy, all were aware of that residents cannot be placed in a room with closed/obstructed door alone for prevention of wandering, and to notify the DON/ADON and the Administrator immediately of any resident involuntary seclusion.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 12/09/2024 from 09:15 a.m. - 12/10/2024 4:00 p.m., 4 CNAs (2 from each shift) and 3 MAs had received training on resident rights, abuse, neglect including involuntary seclusion and were able to identify resident's rights, were0 knowledgeable that residents have the right to wander and that residents cannot be placed in a room with closed/obstructed door alone for prevention of wandering, was aware to notify the DON/ADON and the Administrator immediately of any resident involuntary seclusion.</p> <p>Record review of an In-Service Attendance Record with subject of Abuse and Neglect, dated 06/21/2024, indicated that 38 staff members signed the in-service record.</p> <p>Record review of Incident logs from 12/09/2023 through 12/09/2024 indicated there were no other involuntary resident seclusion incidents at the facility.</p> <p>Record review of CNA A's employee file indicated she received training regarding abuse and neglect during initial orientation on 09/16/2023. CNA A was suspended on 06/21/2024 and terminated on 06/25/2024 for allegation of abuse and neglect.</p> <p>Record review of the facility's policy Abuse Prevention Program, date revised December 2016, indicated Policy Statement Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Record review of the facility's policy Use of Restraints, date revised December 2023, indicated the facility does not use restraints. Policy Interpretation and Implementation: 7. Seclusion, which is defined as the placement of a resident alone in a room, shall not be employed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879</b></p> <p>Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse were reported, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse or neglect resulting in serious bodily injury, to the State Survey Agency, for 2 of 10 residents (Resident #1, Resident #2) reviewed for reporting allegations of abuse.</p> <p>The facility failed to report an allegation of abuse (involuntary seclusion) to the State Agency within 2 hours when it was reported on 06/21/2024 that Resident #1 and Resident #2 was involuntary secluded in their room by CNA A.</p> <p>This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>Record review of Resident #1's Admission Record dated 12/09/2024 indicated she was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which including diverticulitis (a gastrointestinal disease that occurs when pouches in the large intestine wall become inflamed or infected), muscle weakness, abnormal gait and mobility, protein malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), macular degeneration (a disease that causes central vision loss), and depression (mental illness that negatively affects how you feel, the way you think and how you act).</p> <p>Record review of Resident #1's admission MDS assessment, dated 05/13/2024, indicated a BIMS score of 15 which indicated she was cognitively intact and was able to make herself understood and understood others. She was continent of bowel and bladder. Functional Status reflected she required supervision or partial assistance with her ADLs except eating. Resident #1's Mobility Assessment reflected she required supervision or partial assistance with transfers and ambulation.</p> <p>Record review of Resident #1's care plan, dated 05/15/2024, indicated she required limited assistance by staff to move between surfaces and required a rollator walker when ambulating. She was an active participant in structured activities and to encourage resident to participate in activities of choice and respect resident's right to refuse activities that are not desired.</p> <p>Record review of Resident #2's Admission Record dated 12/09/2024 indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fracture of left pubis (a break in the pelvic bone), muscle weakness, abnormalities of gait, dementia (loss of cognitive functioning) and depression (mental illness that negatively affects how you feel, the way you think and how you act).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's admission MDS, dated [DATE], indicated a BIMS score of 2 which indicated she was severely cognitively impaired and was able to make herself understood and understood others. She was always incontinent of bowel and bladder. Functional Status reflected she required moderate to maximum assistance with her ADLs except eating. Resident #1's Mobility Assessment reflected she required moderate to maximum assistance with transfers and did not ambulate used wheelchair for mobility.</p> <p>Record review of Resident #2's care plan, dated 07/06/2024, indicated she was an elopement risk/wanderer disoriented to place, had a history of attempts to leave facility unattended, had impaired safety awareness, and wandered aimlessly. She had interventions for staff to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. She had interventions for staff to identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.</p> <p>Record review of the provider investigation report indicated incident category: neglect, and incident date 06/21/2024, description of allegation: CNA B reported that she went to answer a call light for Resident #1 and Resident #2 and noticed gloves had been shoved in the door frame keeping the door from opening. Provider Response: Administrator and DON immediately started to review cameras to see who placed gloves in the door frame. Local police department was notified. Head to toe assessments were done on resident's, families were notified, and Social Worker interviewed both residents to ensure they were ok, and both were fine and felt safe. Investigation Summary: After reviewing camera footage, it was found that CNA A had placed gloves in the door frame to keep it from opening. She was immediately suspended pending an investigation. DON spoke with CNA A later in the day, and she confirmed that she did put gloves in the door frame. Provider Action Taken Post-investigation: CNA A stated that she put gloves in the door frame to keep Resident #2 from wandering out of the room. CNA A was terminated. An in service was conducted on abuse and neglect. The Social Worker interviewed other residents, and everyone was ok and had no issues. Date and time reported to HHSC 06/21/2024 at 5:07 p.m.</p> <p>Unable to interview Resident #1 or Resident #2 they no longer reside at the facility.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/09/2024 at 4:34 p.m. with CNA B, she said that when she arrived to work on 06/21/2024 at 6:00 a.m., shortly after report around 6:15 to 6:30 a.m., Resident #1's call light came on and she went to answer it. She stated when she arrived at the door entering Resident #1's room it would not open, and she noticed gloves shoved in the door frame above the door handle keeping the door from opening easily. She said she heard Resident #1 on the other side of the door saying she could not open the door that was why she pushed her call light; she was trying to get out of room to go have her morning coffee. She told Resident #1 to stand away for door and she pushed on the door with body/hip forcefully and the door came open. CNA B said she removed the gloves from the door frame and assisted Resident #1 out of the room to get her morning coffee and immediately went to the DON and reported the incident. CNA B said that Resident #1 was a little concerned when she could not get the door open, but once the door was opened and she got her morning coffee, she seemed fine, no signs of distress. CNA B said she returned to the room to check on Resident #2 and she remained in her bed unaware that the event had occurred. CNA B said she called CNA A and ask her about the gloves in the door and she said she had done that to keep Resident #2 from wandering. CNA B said she was told by CNA A that she had placed the gloves in the door frame around 5:30 a.m., while she was providing care to another resident to prevent Resident #1 from wandering out of her room while she was behind a closed door assisting another resident. CNA B said she removed the gloves and opened the door around 6:30 a.m.</p> <p>In an interview on 12/09/2024 at 4:51 p.m. with CNA A, she said on 06/21/2024 around 5:30 a.m. a call light came on for Hall 700, a resident requesting to be changed. While she was in the hallway getting supplies, she noticed Resident #2 was up wandering in the hallway, so she took Resident #2 back to her room and placed her in bed. When she exited the resident's room, she placed gloves in the door frame to keep the door closed so that Resident #2 could not be wandering in the hallway or possibly go outside while she was behind a closed door changing another resident. CNA A said at the time I thought I was protecting [Resident #2], since I was behind a closed door and could not monitor her. My coworker had left early that morning for clinicals, so I was trying to make sure she did not leave her room and wander away while I was occupied with another resident. I was going to go back and remove the gloves when I finished care on the other resident, but I forgot. CNA said when she finished providing care to the other resident she went and took the soiled trash outside to the dumpster and when she entered the facility, the oncoming staff were in the building. CNA A said, at the time I thought I was protecting the resident, but I now understand that was wrong and not to do that again. I was terminated because of the incident. CNA A denied using this technique in the past to keep residents in their room.</p> <p>In an interview on 12/10/2024 at 9:45 a.m. with the DON, he said that he was notified of the incident with Resident #1 and Resident #2's door being hard to open because of gloves in the door frame on 06/21/2024 around 6:30 a.m. The DON said that they immediately started investigating the incident, ADON provided head to toe assessment of both residents, started watching cameras to identify who had placed the gloves in the door frame and interviewing involved staff. The DON said that CNA A admitted that she placed the gloves in the door frame of Resident #1 and Resident #2's door, to keep Resident #2 in her room while she provided care for another resident. The DON said CNA A said she thought she was protecting Resident #2 from wandering out of the room while she was behind a closed door changing another resident. The DON said CNA A was suspended during the investigation and later terminated. The DON said the [NAME] footage confirmed that CNA A was the staff that placed the gloves in the door frame of Resident #1 and Resident #2's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mont Belvieu Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/2024 at 2:15 p.m. with the Administrator, he said he assisted in investigating the incident with Resident #1 and Resident #2's door being hard to open because of gloves in the door frame. The administrator said that he watched camera footage and interviewed involved staff and found that CNA A had placed the gloves in the door frame to keep Resident #2 from wandering out of her room while she was providing care to another resident. The Administrator said that the camera footage confirmed that CNA A placed the gloves in the door frame and that CNA A admitted , during an interview, that she placed the gloves in the door frame and thought she was protecting the resident. The Administrator said CNA A was suspended during the investigation and was later terminated due to the confirmation of abuse/neglect allegation. The administrator said the incident was also reported to the local police department. The Administrator said the residents involved were assessed with no injuries or distress noted, safe surveys provided by social worker with no negative outcomes, families and MD were notified of incident. The Administrator said staff were in-serviced regarding abuse and neglect. The Administrator said that the incident was reported to the State Agency as a neglect incident because he was unaware of what category the incident would fall under. The Administrator said his expectations were that the facility remains free of any resident abuse, neglect, and involuntary seclusion.</p> <p>Record review of the facility's policy Abuse Investigation and Reporting, date revised December July 2017, indicated Policy Statement All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting 2. An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury;</p>		