

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 11/20/2025
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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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: 676484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify the resident's representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment significantly for one (Resident #1) of 10 residents reviewed for changes in condition. The facility failed to notify the responsible party (RP) for Resident #1 when he developed small pleural effusion requiring antibiotic therapy. These failures could place residents at risk for a decline in health, for family members not knowing the health status of the resident, being informed of and participating in care decisions. Findings included: Record review of face sheet dated [DATE] indicated Resident #1 was admitted on [DATE], was a [AGE] year-old male with diagnoses that included acute kidney failure (when kidneys stop working suddenly), muscle weakness, dysphagia (difficulty swallowing), thrombocytopenia (low platelet count), gastrostomy status (a tube directly into the stomach for feeding), septic (infected with microorganisms, especially harmful bacteria), carcinoma (cancer) of oral cavity, diabetes type 2 (chronic condition that affects the way the body processes blood sugar), atrial flutter (heart rhythm disorder), acute embolism (blood clot in blood vessels, partially or completely blocking blood flow) and thrombosis (blood clot forms in a blood vessel) of deep veins of left lower extremity. Record review of Resident #1's clinical admission assessment dated [DATE], authored by RN J indicated he was alert and oriented x 3, oriented to person, time and place. Respiratory status indicated lungs clear throughout bilaterally, no difficulty breathing and no cough noted. Pain assessment indicated no pain or hurting. Record review of Resident #1's care plan indicated it was cancelled as of [DATE] (deceased as of [DATE]) and did not include RP notification for change of condition. Record review of Resident #1's progress health status note dated [DATE] authored by RN H indicated he reported shortness of breath and diarrhea and received orders for bowel rest, hold his g-tube feeding, obtain labs, nebulizer treatments as needed and chest x-ray. There was no documentation the RP was notified. Record review of Resident #1's progress health status note dated [DATE] authored by LVN A indicated chest x-ray sent to MD indicated small pleural effusion (small amount of fluid accumulates in the pleural space, the area between the lungs and the chest wall). MD ordered levofloxacin (a)750 mg antibiotic for 5 days. There was no documentation the RP was notified. Record review of Resident #1's x-ray results dated [DATE] indicated a small pleural effusion. Record review of Resident #1's death certificate dated [DATE] indicated he passed away on [DATE] due to probable acute pulmonary thromboembolism (blood clot travels to and blocks the pulmonary arteries in the lungs). During an interview on [DATE] at 10:30 a.m., the DON said the charge nurse was responsible for notifying the resident RP/family of change of condition, test orders such as an x-ray, test results, and new medication orders. The DON stated her expectation was for nursing staff to notify the family of any change in condition. She stated the family of Resident # 1 should have been notified when he first had a change of status. She said nursing staff should document in the electronic record that the RP/family was notified. In an interview on [DATE] at 10:20 a.m., the Administrator said it was the DON's responsibility to ensure RP/family notification was completed. It was his expectation, if there was a change of condition, the family should be notified as soon as possible. He stated it was important for the family to know what was going on with the resident. The surveyor made two attempts to call LVN A on [DATE] at 12:05 p.m. The number was not available. The facility had no additional contact numbers. The surveyor attempted to call RN H on [DATE] at 12:10 p.m. There was no answer. The surveyor left a voicemail with contact information. RN H did not respond as of the investigation exit. The surveyor attempted to call Resident #1's RP on [DATE] at 11:28 a.m. and 11:30 a.m. There was no answer. The surveyor left a voicemail with contact information. The RP did not respond as of the investigation exit. During an interview on [DATE] at 11:38 a.m., Family Member F said Resident #1's RP was not notified of his change of condition, the x-ray, or the x-ray results. Record review of the facility's Resident Rights policy dated 2001 (revised [DATE]) indicated .be notified of his or her medical condition and of any changes in his or her condition; . Record review of the facility's Change in a Resident's Condition or Status dated 2001 (revised [DATE]) indicated Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. there is a significant change in the resident's physical, mental, or psychosocial status: 5 Except in medical emergencies, notifications will be made within twenty-four (24) hours of a</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 11/20/2025
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>(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 11/20/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and other officials including to the State Survey Agency in accordance with State law through established procedures for 2 of 10 residents (Residents #2 and #3) reviewed for reporting allegations of abuse. The facility failed to report an allegation of misappropriation within 24 hours after Resident #2's RP reported Resident #2's wallet with \$375.40 was missing on 08/06/25. The facility failed to report an allegation of verbal abuse within 2 hours on 08/11/25 when Resident #3's friend reported DA K called Resident #3 a bitch. These failures could place residents at risk of unreported abuse, neglect, exploitation, and a decreased quality of life. Findings included: Record review of Resident #2's face sheet dated 11/04/25 indicated she was a [AGE] year-old female, admitted on [DATE], and her diagnoses included hypoglycemia (low blood glucose level), diabetes (body doesn't make enough insulin or can't use it properly), depression (persistent feeling of sadness), and anxiety (feeling of uneasiness and worry). Record review of Resident #2's admission MDS assessment dated [DATE] indicated she was able to make herself understood and understood others and had moderate cognitive impairment (BIMS-10). There were no noted behaviors. Record review of Resident #2's care plan dated 08/15/25 indicated she had decided to have a surveillance camera in her room[KS1] . Record review of a grievance form dated 08/06/25, indicated Family Member X [KS2] reported to a charge nurse that Resident #2's wallet with \$375.35[KS3] was missing. The wallet and money were in a dresser drawer between clothes upon admission on [DATE]. Family Member X indicated she checked the wallet daily and on 08/06/25, the wallet was no longer in the dresser drawer. The missing wallet and money were reported to the Administrator on 08/06/25. The Administrator noted on 08/11/25 he spoke to Resident #2 regarding the missing money. She stated she wasn't sure how or when her wallet went missing. When asked if she felt safe or worried, she said she was fine and showed no emotional distress. The administrator searched Resident #2's room, closet, and drawers and nothing was found. The administrator and DON interviewed all staff assigned to the area including nursing, housekeeping, laundry, and dietary regarding the missing money for several days. All staff were unaware of the grievance and recalled no concerns/distress from Resident #2. On 08/12/25 the Administrator spoke with Resident #2 again to see if she recalled anything and to make sure she still felt safe. She stated everything was fine and showed no signs of distress. On 8/13/25 the Administrator spoke to Resident #2's responsible party and family member T. The Administrator informed her of the investigation process, lack of findings to date and what potential outcomes may be. She confirmed the initial report that stated the only visitor that Resident #2 had recently was family member R, which happened to be on the same day as the wallet came missing but didn't believe she would have taken it. The Administrator informed her the facility would continue to interview staff regarding the missing money and would also be providing re-education to staff regarding abuse and neglect and theft. The RP was satisfied with our efforts and current outcome. Investigation/search would continue. There was no indication that the allegation of misappropriation was reported to HHSC. Record review of Resident #2's progress note dated 08/20/25, completed by LVN A indicated Resident #2 was discharged on to hospital and did not return to the facility. Record review of Resident #3's face sheet dated 11/04/25 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included nonrheumatic aortic valve stenosis (the valve is narrowed and doesn't open fully), cognitive communication deficit (communication challenge), anxiety (feeling of uneasiness and worry), unspecified intellectual disabilities, and persistent mood (affective) disorder (chronic form of depression). Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others and was cognitively intact (BIMS-15). There were no noted behaviors. Record review of Resident #3's care plan dated 09/14/25 indicated no focus related to the allegation. Record review of Resident #3's progress not completed by RN M indicated Resident #3 passed away on 10/02/25[KS4] . Record review of a grievance dated 08/11/25 reported to the DON, indicated Resident #3 claimed DA K was rude and called her a bitch. The administrator was notified on 08/11/25. The Administrator noted on 08/18/25 he spoke with Resident #3's [KS5] family</p>		