

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  02/19/2026
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #1) reviewed for infection control. RN A failed to properly dispose of used sharps on [DATE] and they were left hanging attached to an IV pole. On [DATE], EMS B was stuck by the used sharps when she grabbed the IV pole to utilize during CPR. This failure could place residents and staff at risk of exposure to communicable diseases and infections. Findings included: Record review of Resident #1' face sheet dated [DATE] indicated he was a [AGE] year-old male admitted on [DATE], and his diagnoses included encephalopathy (damage or disease that affects the brain), anemia (deficiency of red blood cells), diabetes (blood sugar is too high), depression (mental health condition), anxiety (excessive worry), heart disease, kidney disease, and liver transplant status. Record review of Resident #1's physician orders dated [DATE] indicated may insert IV on [DATE] and change to clysis (medical introduction of fluids into the body, typically by injection, to replace lost fluids, provide nutrients, or maintain blood pressure.) Record review of Resident #1's progress note dated [DATE] at 10:14 p.m. by RN A indicated the clysis that was inserted into the left upper arm was dislodged. The site was leaking clear fluid and was cleansed and patted dry. MD was notified. During an interview on [DATE] at 1:15 p.m., RN D said on [DATE] she attempted to insert an IV to administer IV fluids for Resident #1 and was not successful. She said she obtained order to change the IV to clysis. She said she left her shift on [DATE] at approximately 6:30 p.m. and Resident #1 was receiving fluids as ordered. She said she returned to work her shift at 6:00 a.m. on [DATE] and was informed the clysis had been dislodged. She said the MD did not order re-insertion of the clysis. She said on [DATE] Resident #1 was found unresponsive and emergency CPR was initiated. She said EMS arrived and took over. She said she heard EMS E tell EMS B there was an IV pole. She said EMS B grabbed the IV pole and screamed she was stuck. RN D said she removed the bag of saline and used sharps from the IV pole and disposed them into the garbage bin at the nurse station. She said she knew she should dispose of the sharps into the used sharps container but she was waiting until EMS looked over the bag and used sharps. She said EMS B and EMS E checked the bag to make sure there was no medications included in the saline solution. RN D said she then disposed of the used sharps in the sharps container and the bag of saline was disposed of into the trash. She said the used sharps should have been disposed of in the sharps container immediately and not left on the IV pole in Resident #1's room. She said Resident #1 did not have a room mate. She said other residents and staff were at risk of exposure to communicable diseases and infections if sharps were not disposed of correctly. During an interview on [DATE] at 1:43 p.m., the ADON said all used sharps should have been disposed of in the sharps container and not left on the IV pole in Resident #1's room. She said Resident #1 did not have a room mate. She said other residents and staff were at risk of</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  676484	Facility ID:  676484  If continuation sheet Page 1 of 2

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  02/19/2026
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>exposure to communicable diseases and infections if sharps were not disposed of correctly. During an interview on [DATE] at 2:09 p.m., the Administrator said the used sharps should have been disposed of correctly in the sharps container. He was not made aware of incident when EMS B was stuck with the used sharps when it occurred on [DATE]. He said he received an email from the Fire Marshall regarding the incident on the evening of Sunday [DATE] that he did not open until Monday [DATE]. During an interview on [DATE] at 2:13 p.m., RN A said CNA F came and told her Resident #1's clysis was dislodged on [DATE]. She said there was no order to re-insert. She hung the tubing and used sharps high on the IV pole. She said she was going to go back and dispose of the used sharps and saline but she got busy with other residents and forgot to dispose of the used sharps in the sharps container. She said the used sharps should have been disposed of in the sharps container and not left on the IV pole in Resident #1's room. She said other residents and staff were at risk of exposure to communicable diseases and infections if sharps were not disposed of correctly. During an interview on [DATE] at 9:14 a.m., EMS B said she went into Resident #1's room and took over CPR on [DATE]. She said an epi drip (intravenous infusion of epinephrine used to support blood pressure, heart rate, and cardiac output in critically ill or anaphylactic patients) was started and she was holding the bag when EMS E noticed the IV pole. She said the IV pole had a bag of saline hanging on it. She said she was removing the bag of saline when she was stuck with the sharps. She said there was subcutaneous sharps attached that she did not see when she grabbed the bag of saline. She said RN D took the bag of saline and attached tubing and sharps from the room. She said she pulled up her glove and put a bandage over the area where she was stuck by the sharps. She said the CPR was continued until Resident #1 was pronounced deceased . She said she went to the nurse station and asked RN D to see the bag. She said RN D said she threw it away and when she asked to see it, RN D went to the trash and pulled the bag and used sharps out of the trash. She said RN D did not dispose of the used sharps into a sharps container. Record review of the facility's Sharps Disposal policy dated 2001 (revised [DATE]) indicated This facility shall discard contaminated sharps into designated containers. 1. Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers. 2. Contaminated sharps will be discarded into containers that are: a. Closable; b. Puncture resistant; c. Leakproof on sides and bottom; d. Labeled or color-coded in accordance with our established labeling system; and e. Impermeable and capable of maintaining impermeability through final waste disposal. 7. Whoever observes incorrect disposal or handling of contaminated sharps should report the information to the Infection Preventionist (or designee).</p>		