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| 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 03/11/2026 |
| 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) |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one of four residents (Resident #1) reviewed for accident hazards/supervision/devices. The facility failed to ensure CNA A used a gait belt when transferring Resident #1 from her wheelchair to the bed on 03/10/2026. This failure could place the residents at risk for discomfort, pain, falls, injuries, and skin tears. Findings included: Record review of Resident #1's face sheet, dated 03/11/2026, indicated a [AGE] year-old female, admitted [DATE]. Diagnoses included dementia (loss of cognitive functioning), cognitive impairment, dysphagia (difficulty swallowing), history of falls, anxiety disorder (persistent and excessive worry that interferes with daily activities) and depression (mental illness that negatively affects how you feel, the way you think and how you act). Record review of Resident #1's MDS, dated [DATE], indicated she was unable to complete a brief interview for mental status. She had short- and long-term memory problems and was severely impaired cognitively. Record review indicated she was dependent on staff for chair to bed transfer. She was always incontinent with urine and bowel. She had sustained two falls without injury and one fall with minor injury since the prior assessment. Record review of Resident #1's care plan, dated 02/27/2025, indicated Resident #1 had a self-care performance deficit and was dependent on staff for most ADLs. Record review indicated an intervention for ADL care transfers, bathing, bed mobility, toileting, dressing, personal hygiene, oral care and locomotion required total assistance by one (1) staff to provide care. During an observation on 03/10/2026 at 3:45 p.m., Resident #1 was observed being assisted from her wheelchair to the bed by CNA A. Resident #1 was able to hold to the side rail of the bed but required extensive assistance to stand up with CNA A's arm around her body (chest area) and pulling her up to standing position, pivoted her close to bed and then lowered her to the bed, and picked up her feet removed shoes and placed her feet on the bed assisted her to a lying position in bed. Resident #1 was very unsteady and shaky during the transfer. No gait belt was used during the transfer. Resident #1 did not express any signs of pain or discomfort during or after the transfer. During an interview with the DOR on 03/11/2026 at 12:15 p.m., she said the facility does annual transfer training and with specific staff and residents as the need arises. She said Resident #1 had received therapy services due to a history of falls. She said therapy does participate in care plan meetings and determined transfer status. She said she is a speech language pathologist, and the physical and occupational therapist does most of the transfer training and it would be best to interview with one of them regarding transfer training. During an interview with COTA B on 03/11/2026 at 2:15 p.m., she said she assisted with providing facility staff transfer training annually and with specific staff and residents as the need arises. She said Resident #1 had received therapy services due to a history of falls. She said therapy does participate in care plan meetings and determined transfer status. She said Resident #1 required assistance of one (1) staff with transfers. She said staff should be utilizing a gait belt during Resident #1's transfers. She said it was not acceptable to lift someone under their arm pits or around chest area (bear hug technique) due to the potential for injury not only to the resident but also to the (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>caregiver/staff. She said staff should use a gait belt with all manual lifting of residents for safety. She said not using a gait belt or proper transfer technique could increase the risk of falls or injuries. During interviews with direct care staff (CNA F, CNA G, CNA H, CNA J, CNA K, CNA L, LVN M, LVN N, LVN O, LVN P) on 3/11/2026 from 9:30 am to 3:00 pm staff said that they were to utilize a gait belt for residents requiring one-or two-person manual transfers. During an interview with CNA A on 03/11/2026 at 3:00 p.m., she said she should have used a gait belt for the transfer with Resident #1 and not utilized the bear hug transfer technique because it could cause injury to her arms/shoulders. CNA D said she tried not to put her hand directly under Resident #1's arm pits to prevent injury. She said she got nervous about being observed during the transfer and forgot to use a gait belt. She said she had been trained on using a gait belt during transfers. She said she notified the ADON and administrator she did not utilize a gait belt during the transfer observation and they placed her on immediate suspension until she could be properly trained on performing a safe transfer by therapy staff. She said she remains on suspension awaiting a call from facility therapy department for her transfer training scheduled appointment. During an interview with the ADON on 03/11/2026 at 3:15 p.m., she said she expected staff to use a gait belt when manually transferring a resident. She said the risk of staff not following the correct procedure for transfers was injury to a resident's shoulders and arm and or the risk of the resident falling causing an injury. She said she and the administration had talked with CNA A regarding her observed transfer of Resident #1 on 3/10/2026 and she acknowledged she did not use a gait belt during the transfer. The ADON said CNA A was placed on suspension on 3/10/2026 immediately upon notification of not utilizing a gait belt during the transfer and was scheduled to meet with therapy department for one-on-one transfer training and she would not be allowed to return to work until her training was completed and proper technique demonstrated. She said a safe lifting and movement of residents' in-service with all the staff will be conducted to ensure staff were providing correct transfer techniques. During an interview with the Administrator on 03/11/2026 at 4:15 p.m., he said the facility staff should utilize and follow safe transfer practices, which would include utilizing a gait belt during manual transfers. He said staff should utilize appropriate techniques and devices to lift and move residents properly and safely. He said not using the proper devices to manually lift residents could cause pain, falls, and possible injury. Record review of CNA A's personnel file indicated she was rehired on 07/27/2025 and the staff education/orientation checklist indicated she had received training on safe transfers on 07/27/2025 and had met the criteria for proper technique. Record review of the facility's policy, Safe Lifting and movement of Residents revised July 2017, indicated, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include the following: a. Resident's preferences for assistance; b. Resident's mobility (degree of dependency); c. Resident's size; d. Weight-bearing ability; e. Cognitive status; f. Whether the resident is usually cooperative with staff; and g. The resident's goals for rehabilitation, including restoring or maintaining functional abilities. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.</p> | | |