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	01/08/2025

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

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 2 residents (Resident #32) reviewed for enteral feeding. The facility failed to ensure LVN C mixed crushed medications with water and administered one medication at a time when giving medications to Resident #32 through her G-tube (a tube inserted through the wall of the abdomen directly into the stomach which allows the delivery of nutrition, fluids, and medications directly into the stomach). The facility failed to ensure LVN C administered Resident #32's G-tube medications by gravity, and instead she pushed the medications using the plunger of the syringe. These failures could place residents receiving enteral nutrition and medications at increased risk of not receiving proper nutrition, infection, and aspiration. Findings include: Record review of a face sheet dated 01/07/24 indicated Resident #32 was a [AGE] year-old female and admitted to the facility 12/14/20. Her diagnoses included dysphagia (difficulty or discomfort swallowing) and aphasia (affects the ability to communicate) following cerebrovascular disease (a group of conditions that impact the brain's blood vessels and blood flow). Record review of the most recent quarterly MDS dated [DATE] indicated Resident #32 had no speech and was sometimes understood and usually understood most conversation. She had a BIMS score of 0 indicating severe cognitive impairment, required partial/moderate assistance with most ADLs, and required a feeding tube for all nutrition and fluid intake. Record review of a care plan last revised 12/05/25 indicated Resident #32 required a feeding tube related to dysphagia and was at risk for aspiration (breathing in a foreign object such as food). Interventions included to dissolve each medication in 10 cc (cubic centimeter equal to a volume of one milliliter) water and flush with 10cc water between each medication. (continued on next page)

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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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of physician orders dated January 2025 indicated Resident #32 was NPO (nothing by mouth) and was to receive all feedings, water and medications via G-tube. Orders indicated flush tubing with 30 cc water before and after medication administration and dissolve each crushed medication in 10 cc water and flush with 10cc water after each medication. During an observation of medication administration on 01/07/25 at 9:20 a.m., LVN C crushed eight medication tablets together and poured them in a medication dose cup. She washed her hands and gowned and gloved. She checked placement of the G-tube by aspirating stomach contents and flushed the tubing with 30 cc water. She poured the dry crushed medications into the syringe with the water used to flush the tubing. The fluids and medications stopped flowing into the tubing. LVN C poured the contents of the syringe into a cup and used the plunger of the syringe to force the tube open. She removed the plunger and poured the contents of the cup back into the syringe. The G-tube leaked a small amount and then flowed per gravity drainage. She then added 30 cc of water and began administration of feeding of 375 cc DiabetaSource AC (specialized nutrition solution). The gravity flow of the feeding slowed, and she used the plunger of the syringe to hasten the flow. The feeding was completed, and she flushed the tubing with 30 cc water. During an interview on 01/07/25 at 2:02 p.m., LVN C said she normally dissolved each medication in water and administered one medication at a time. She said she should have crushed Resident #32's medications separately and dissolved each medication in 10 cc water and given them one at a time, but she was so nervous being watched that she didn't follow her normal procedure. She said she shouldn't have used the plunger of the syringe to unclog the tubing and that G-tubes should only be flushed by adding water and letting the water flow by gravity. She said crushing all the medications together and not mixing them with water had caused the tube to stop up. She said flushing the G-tube using a plunger could cause irritation to the resident's stomach. She said she had received training on G-tubes during her orientation and yearly at the facility. She said the facility did yearly skills check offs that included G-tubes. During an interview on 01/07/25 at 02:53 p.m., the DON said he expected all nurses to follow facility policy when administering G-tube medications. He said the policy indicated to administer one medication at a time diluted by water and to never use the piston (plunger) of the syringe when flushing the G-tube or administering medications. He said by giving one medication at a time the nurse would know what medication did not enter the stomach if the G-tube clogged. He said using the plunger of the syringe to unclog or flush the G-tube could cause rupture of the stomach. He said LVN C was observed yearly giving G-tube medications and during the observations she administered one medication at a time diluted in water and flushed the G-tube with water using gravity flow. Record review of a skills observation of administering medications/feedings through an enteral feeding tube dated 09/24/24 indicated LVN C diluted each medication with water and gave each medication separately and allowed all fluids given to administer by gravity flow. Record review of the facility policy titled Administering Medications through an Enteral Tube revised March 2024 indicated .10. Dilute medication: a. Remove plunger from syringe. Add medication and appropriate amount of water to dilute. b. Dilute crushed (powdered) medication with prescribed amount of water. 11. Administer each medication separately. 12. Reattach syringe (without plunger) to the end of the tubing. 13. Administer each medication by gravity flow: a. Pour diluted medication into barrel of the syringe while holding the tubing slightly above the level of insertion. B. Open the clamp and deliver medication slowly. C. Begin flush before the tubing drains completely

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22183 41057 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 6 residents observed for oxygen management. (Resident #76) The facility failed to keep the oxygen concentrator (machine that takes air from your surrounding and extract oxygen and filter it into purified oxygen to breath) filter clean for Resident #76 and humidifier bottle (oxygen can be drying to your nose so some patients use a humidifier bottle to moisten the oxygen you breath) filled with water. These failures could place residents at risk of a significant reduction in the quality of oxygen being delivered, inadequate oxygen support, and decline in health. Findings included: Record Review of Resident #76's face sheet dated 01/06/25, indicated he was a [AGE] year-old male admitted on [DATE] with a diagnosis of atherosclerotic heart disease (a build of fatty deposits in the inner lining of the coronary arteries that may cause shortness of breath). Record Review of Resident #76's most recent quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 10 which indicated moderate cognitive impairment. The assessment indicated a medical diagnosis of atherosclerotic heart disease. Record Review of Resident #76's care plan revised 11/20/24 indicated he had altered cardiovascular status with interventions of requires oxygen use, ensure setting and delivery method are appropriate and correct. A care plan indicated he had oxygen therapy with an intervention to monitor for signs and symptoms of respiratory distress. Record Review of Resident #76's Physicians Order Summary dated 01/08/25 indicated he was prescribed oxygen at 2 - 5 liters per minute by nasal canula for shortness of breath or if oxygen saturation (a measure of how well the lungs are working) was below 93%. During an observation on 01/06/25 at 10:20 a.m., Resident #76 was lying in bed with oxygen per nasal canula on at 2.5 liters/ minute to an oxygen concentrator. Resident #76 said he used his oxygen daily now. The humidifier bottle was empty, and the oxygen concentrator's filter was covered with a thick grey powdery, dusty substance. During an observation on 01/07/25 at 08:00 a.m., Resident #76 was lying in bed with oxygen per nasal canula on at 2.5 liters/ minute the humidifier bottle was empty, and the oxygen concentrator filter was covered with a thick grey powdery, dusty substance. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/06/25 at 03:54 p.m., LVN C said she was providing care for Resident #76 today. She said he received oxygen as needed and was receiving oxygen currently. She said the humidifier bottle on the oxygen concentrator was empty and needed to be changed and she would change it. LVN C said the oxygen concentrator filter was dirty and should have been changed. She said she would get it cleaned. LVN C said she was responsible to ensure the oxygen concentrator filter was clean and the humidifier container be changed out and have water in it. She said the DON and ADON were the back up to double check oxygen concentrator filters were clean and oxygen humidifier bottles were changed when empty. She said it was overlooked. LVN C said it was not a resident risk for the humidifier bottle to be empty, the oxygen was just not humidified. She said a dirty oxygen concentrator filter was a resident risk of not allowing proper air exchange by the oxygen concentrator. During an interview on 01/07/25 at 3:59 p.m., the DON said the nurses were responsible to ensure the oxygen concentrators humidifier bottles were changed when needed. He said maintenance was responsible for cleaning the oxygen concentrator filters. He said the facility did not have a double check but would now have one. The DON said the empty humidifier bottle and dirty oxygen concentrator filter were overlooked. He said the staff were educated to change out the empty humidifier bottles and maintenance was educated to change or clean the dirty filter on the oxygen concentrators. He said the humidifier bottle being empty was not a risk, it was for comfort to humidify the oxygen. The DON said the resident risk of a dirty oxygen concentrator filter could decrease performance of the oxygen concentrator and not be as effective. He said his expectation was oxygen humidifier bottles be changed when necessary, tubing changed on 10/ 6 shift on Sundays and oxygen concentrator filters checked and if dirty notify the DON or ADON and they would have maintenance clean them until the nurses could be in-serviced on the proper way to clean the filters. During an interview on 01/08/25 at 8:30 a.m. the Maintenance Director, said the nurses were responsible to ensure the oxygen concentrator filters were cleaned if the filter was not covered by the machine as Resident #76's was. He said he cleaned the machines, serviced them and tagged them as clean. If he could not repair the machine, he would send it out for repair. The Maintenance Director said the nurses clean the filters after he sends out the machine and he was not sure what happened he said the nurse was responsible. He said he was educated on cleaning the concentrators and adding a clean filter. The Maintenance Director said the risk of a dirty filter on an oxygen concentrator was the concentrator may not work properly and could affect air going through it. During an interview on 01/08/25 at 11:48 a.m., the Administrator said the nurses were responsible for ensuring the oxygen concentrator humidifier bottles were filled or changed out and maintenance was responsible for cleaning the filters on the oxygen concentrator for now. He said the double check was administrative rounds. He said HR was Resident #76 administrative round person. The Administrator said the nurses were educated on changing out empty humidifier bottles and maintenance was educated on cleaning oxygen concentrators filters. He said they were overlooked. The Administrator said the resident risk of the dirty concentrator filter was decreased air flow and could affect the oxygen concentrator performance. He said the humidifier bottle not filled was not a resident risk the water was for comfort. The Administrator said his expectation was for all staff to follow policy and procedures. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 12:30 p.m., the HR said she made administrative rounds on Resident #76 normally and she was to double check on the oxygen concentrators filters and humidifier bottles. She said she would tell the nurse the humidifier bottle was empty and tell maintenance the oxygen concentrator filter was dirty. She said it was overlooked, she did not make rounds this week. The HR said the risk of a dirty oxygen concentrator filter was it could affect air flow to the oxygen concentrator, but she was unsure what effect an empty humidifier bottle could have on a resident. She said she was educated to check on the resident ask about pain, if clean and changed and care received and check if equipment was clean and working. Record Review of a facility policy revised 2009, titled, Maintenance Service indicated, . The Maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Record Review of a facility policy revised October 2010, titled, Oxygen Administration indicated, . 12. Check the mask, tank, humidifying jar, .to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. 14. Periodically re-check water level in humidifying jar. 15. Periodically check oxygen tubing and delivery device . to ensure cleanliness and change as necessary.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate administering of medications for 2 of 18 residents reviewed for pharmaceutical services. (Residents #2 and #19) The facility failed to ensure medication was not left at bedside for Resident #2. The facility failed to administer midodrine HCL prn as ordered on 01/02/25 and 01/06/25 when Resident #19's blood pressure was below prescribed parameters. These failures could place the residents at risk of not receiving the appropriate medications and services to maintain their highest practicable well-being. Findings included: 1. Record review of a face sheet dated 01/08/25 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included morbid (severe) obesity due to excess calories and age-related cognitive decline (subtle decline that affects thinking speed and attention). Record review of an annual MDS dated [DATE] indicated Resident #2 had a BIMS score of 15 indicating she was cognitively intact, was always understood and able to express ideas, and required partial/moderate assistance with most ADLs, Record review of physician orders dated January 2025 indicated Resident #2 was to receive Senna Oral Tablet 1 tablet by mouth two times daily for constipation. Record review of a care plan revised 01/06/25 indicated Resident #2 was at risk for constipation related to decreased mobility. During an observation and interview on 01/07/25 at 06:50 a.m., LVN D was administering a hydrocodone/APAP 5-325 mg 1 tablet every 6 hours as needed for pain for a complaint of right leg pain 10/10 on the pain scale. LVN D watched the resident swallow her medication. Resident #2 asked LVN D if she could take a Senna tablet in a dosage cup that MA B had left with her that morning along with her other medications to take. She said she noticed in the cup and did not want to take the pill because her bowels had been loose. LVN D took the Senna tablet and said she would dispose of it. LVN D said facility policy said for the nurse or the MA to ensure all medications were taken by the resident and never leave medications at bedside. During an interview on 01/07/25 at 06:59 a.m., MA B said she left Resident #2's morning medications with her to take that morning. She said she was trying to hurry and did not stay to watch the resident take the medications and did not know that she had not taken her Senna tablet. She said the facility policy was to stay with the resident until all medications were taken. She said because she did not stay, she did not know the Senna tablet was not taken. She said she should have stayed with Resident #2 and reported to LVN D that she did not take her Senna because she was having loose stools. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/25 at 10:30 a.m., the DON said it was the facility's policy for nurses and Mas to remain with a resident until all medications were administered and to not leave medications at the bedside. He said leaving medications at the bedside could result in the resident not getting their medications as ordered. During an interview on 01/08/25 at 8:25 a.m., Resident #2 said MA B usually waited while she took her medications, but she was one of the residents she could leave the medications with and she would remember to take them. During an interview on 01/08/25 at 1:38 p.m., the Administrator said he expected all nurses and MAs to stay with the residents until medications were taken and never leave medications at the bedside. Record review of a facility policy titled Administering Medications revised April 2019 indicated . Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care-planning team, has determined that they have the decision-making-capacity to do so safely. 2. Record review of Resident #19's Face sheet dated 01/06/25 indicated she was admitted on [DATE], was [AGE] years old with diagnoses which included hypertension (high blood pressure), and hypotension (low blood pressure) related to diabetes. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #19 had a BIMS score of 12 which indicated cognition was moderately impaired. She had a diagnosis of hypertension. Review of Resident #19's care plan dated 12/18/24 indicated the resident had diagnosis of hypotension related to diabetes. The interventions included give medications as ordered. Monitor for side effects and effectiveness and to monitor vital signs as ordered. Record review of physician orders dated January 2025 indicated Resident #19 was prescribed carvedilol 6. 25 mg (used to lower blood pressure) twice daily for hypertension. The orders indicated to hold for blood pressure less than 110/60; and hold for heart rate below 60. Included was an order for midodrine HCL (used to treat low blood pressure) 5 mg every 12 hours as needed for hypotension (low blood pressure) - administer for systolic blood pressure below 100. Record review of Resident #19's MAR dated 01/01/25 through 01/06/25 indicated the following: 01/02/25 at 9:00 a.m., carvedilol 6.25 mg was held due to B/P 95/50; and 01/06/25 at 9:00 p.m., carvedilol 6.25 mg was held due to B/P 89/50. Record review of the MAR dated 01/01/25 through 01/06/25 gave no indication Resident #19 was administered midodrine 5 mg as prescribed by physician when the SBP was below 100 on 01/02/25 or 01/06/25. (SBP refers to the pressure in your arteries when your heart pumps blood throughout your body. It is the top number in a blood pressure reading). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 01/08/25 at 9:45 a.m., LVN A acknowledged Resident #19's carvedilol had been held on 01/02/25 and 01/06/25 due to B/P outside prescribed parameters. She also said Resident #19 should have received midodrine 5 mg due to SBP below 100. LVN A said there was no documentation in Resident #19's electronic medical record to indicate it had been administered. She said MAs were responsible for taking vital signs of residents prior to administration of medications. She said anytime vital signs were outside of prescribed parameters, the MAs were to inform LVNs. Although LVN A was not on duty on these occasions, she said the nurses were responsible for administering PRN medications to residents. LVN A said potential negative outcome of not receiving prescribed medication included lethargy and blood pressure could continue to decrease. During an interview on 01/08/25 at 9:50 a.m., MA B said when a resident had blood pressure or heart rate outside of prescribed parameters, the charge nurses were notified and the nurse reassessed residents. During a joint interview and record review on 01/08/25 at 10:15 a.m., the DON and ADON said Resident #19's carvedilol had been held on 01/02/25 and 01/06/25 due to her B/P being outside the prescribed parameters. They said midodrine should have been given to Resident #19 as prescribed by the physician when her B/P fell outside the prescribed parameters. The DON said he expected nursing staff to check the resident's electronic record for PRN orders regarding decreased blood pressure readings. He said residents would not achieve therapeutic levels of medications if not adjusted. The ADON said possible negative outcomes included the B/P could continue to decrease. The DON said he expected the nursing staff to administer all medications as prescribed by the physician as intended. During an interview on 01/08/25 at 10:45 a.m., the Administrator said his expectations were for all residents to have medications administered as prescribed by the physician. Record review of the policy Administering Medications revised April 2019 indicated . Medications are administered in a safe and timely manner, and as prescribed.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview and record review, the facility failed to ensure residents were provided the therapeutic diets as prescribed by the attending physician for 1 of 18 residents (Residents #21) reviewed for therapeutic diets food and nutrition services. The facility failed to ensure Resident #21 received a CC (control carbohydrate) diet (diet to help manage blood sugar) with the breakfast meals on 01/07/25 and 01/08/25 as ordered by physician. This failure could place residents with diet needs at risk for an increase in blood sugar level and potential decline in health. The findings included: Record review of Resident #21's admission record dated 01/07/25 indicated she was [AGE] years old and admitted on [DATE] with diabetes (disease that results in too much sugar in the blood). Record review of the physician's orders dated 01/07/25 indicated Resident #21's diet was NAS (no added salt), CC (controlled carbohydrate) diet with a start diet of 02/26/24. Record review of the MDS quarterly assessment dated [DATE], indicated Resident #21's BIMS score was 15 indicating no impairment with cognition. She required assist with set up or clean up; resident completed activity for eating. No weight loss or gain of 5% or more in the last month or loss of 10% or more in the last 6 months was noted. Therapeutic diet was noted. Resident #21 received hypoglycemic medication during the last seven days and had a diagnosis of diabetes. Record review of the care plan dated 10/21/24 indicated Resident #21 had diabetes and approaches included . Medication as ordered by doctor, Monitor/document for side effects and effectiveness, and Dietary consult for nutritional regimen and ongoing monitoring. Discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. Monitor/document/report PRN compliance with diet and document any problems. During an interview on 01/06/25 at 10:40 a.m., Resident #21 said the kitchen always sent her regular condiments like syrup with sugar and regular jelly. She stated, I am a diabetic and I get insulin. She said she told someone, but she was unsure who or when. During an observation and interview on 01/07/25 at 8:00 a.m., Resident #21's breakfast tray had a package of regular grape jelly. She said they were still sending the wrong condiments. During an interview on 01/07/25 at 8:30 a.m., LVN D said she had checked Resident #21's breakfast tray and missed the jelly being regular. She said with the resident getting regular jelly, it could elevate her blood sugar. She said she was responsible for checking the tray and she had been trained. During an interview on 01/07/25 at 9:00 a.m., the DON said he would check with the dietician about the grape jelly to verify if the residents on the CC diet could have regular jelly. (continued on next page)

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/25 at 9:45 a.m., the DM said the residents on the CC diet should have received diet jelly and provided the dietary card with items listed for the CC diet for Resident #21. During an interview on 01/7/25 at 2:00 p.m., the DON said he had spoken to the dietician and thought it was ok. He stated you can speak to the DM and Dietician to clarify. During a telephone interview on 1/7/25 at 2:20 p.m., the Dietician said if the menu extension for CC indicated DT Jelly, the resident should receive the diet jelly. She said to check with the DM that she gave them the diet extension. She also said it always comes back to resident preference too. During an interview on 01/7/25 at 3:00 p.m., the Administrator said the meals should be served as ordered unless the resident requested something different. During an observation on 01/8/25 at 8:30 a.m., Resident #21 pointed at her breakfast tray and said the kitchen still sent regular syrup for her breakfast. She stated, I am a diabetic and need diet condiments. During an interview on 01/8/25 at 9:15 a.m., the DM said the dietary was responsible for sending the correct condiments. The DM said the residents on CC diet should have received diet syrup. She said Resident #21 was served regular syrup on her breakfast tray today and should have been served diet syrup. During an interview on 01/8/25 at 10:45 a.m., the dietician said the residents on the CC diet should have been served diet syrup for breakfast. Record review of the diet card dated 01/07/25 indicated Resident #21 was on a CC diet and should be served DT (diet) jelly for her toast. Record review of the diet card dated 01/08/25 indicated Resident #21 was on a CC diet and should be served DT (diet) syrup for her waffle.

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	01/08/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22183 Based on observation, interview, and record review the facility failed to store and distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food safety. 1. The facility failed to ensure stored foods were properly labeled and dated. 2. The facility failed to ensure expired foods were discarded. 3. The facility failed to store foods in accordance with professional standards. These failures could place residents who ate the food from the kitchen at risk for food-borne illness and a diminished quality of life. Findings included: During observation and interview on [DATE] at 8:25 a.m., an initial tour of the kitchen was conducted with the Dietary Manager, the following was observed: Refrigerator #2 indicated: (1) gallon bag of [NAME] Creek Sliced American cheese with no date opened and exposed to air. Prep-refrigerator indicated: (1) tray of 18- 8ounce cups of white liquid substance with plastic wrapped lids with no label of what the item was or date prepared. [NAME] substance was identified by Dietary Manager as milk. Dry pantry indicated the following: (1) 750ml bottle of Barrel & Bean vanilla-hazelnut sugar-free syrup ,d+[DATE] used with a manufacture best by date of ,d+[DATE]. (1) 1-gallon bottle of distilled white vinegar ,d+[DATE] used with no date when opened (1) 1- pound bottle of Smucker's Raspberry dessert topping ,d+[DATE] used with a manufacture best by date of ,d+[DATE]. The Dietary Manager said both were used to decorate cakes, but may not have the same taste if used after the best by date. (1) 1-bowl used as a scoop left in the brown sugar container. (continued on next page)

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	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 8:59 a.m., the Dietary Manager said the expectation for dating items in the refrigerator and freezer were for all items to have a handwritten date received and if the items were opened then a date opened. She said she and the kitchen aides were responsible for making sure staff in the kitchen put the items in bags and if taken out of their original boxes and making sure the items were labeled and dated when they arrived and when they were first opened. The Dietary Manager said the food must be labeled and dated properly to prevent cross contamination from using spoiled foods. She said eating outdated foods could make residents sick. The Dietary Manager said the staff were trained to properly store food by labeling it when it was opened and sealing it to reduce its exposure to the elements. Record review of Food Ordering, Receiving and Storage revised [DATE] reflected, Policy Interpretation and Implementation . 7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date) 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE]. 11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety