STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455582	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Villa Healthcare Center	1800 13th St Bay City, TX 77414

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on observation interview and record review, the facility failed to ensure that each resident had a right to secure and confidential personal and medical records for two (Resident #3 and Resident #4) of five residents reviewed for privacy. 1. RN A walked away and left Resident #3's personal information unattended and in display in the resident data portal. 2. Resident #4's MAR was left unlocked and unattended on a laptop at the nurses station. This failure could place 55 residents who's personal information is stored in the resident data portal at risk of personal information being exposed to unauthorized individuals. Findings Included: Record review of Resident #3's face sheet revealed a sixty-eight-year-old man who was initially admitted on [DATE]. His admitting diagnoses were Type 2 Diabetes (chronic condition that happens when you have persistently high blood sugar levels), heart failure, chronic kidney disease (involves a gradual loss of kidney function), and gout (a type of inflammatory arthritis that causes pain and swelling in your joints). Record review of Resident #4's face sheet revealed a seventy-eight-year-old woman who was initially admitted on [DATE]. Her admitting diagnoses were cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), dementia (memory loss), hypertension (high blood pressure), gout (a type of inflammatory arthritis that causes pain and swelling in your joints), and sepsis (occurs when chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body). In an interview on 05/15/24 at 11:53 am with RN A, she stated that she had been working at the facility since July 2023. She explained that as a nurse she did g- tubes, tracheostomy care, wound care, and change in conditions in patients. RN A was asked to pull up Resident #3's chart in the facility data portal. During the interview, a resident's call light went off at 11:54 am. She excused herself to answer the call light and returned to the interview at 11:57am. RN A and the investigator walked around inside the nurse's station and the computer screen was left unlocked and the face sheet for a Resident #3 was left exposed. She proceeded to go into Resident #3's profile. (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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a continued interview on 05/15/24 at 12:12 pm, The investigator began to walk away from the nurse's station to the dining room to observe residents during lunch. RN A also began to walk with the investigator to the dining room because she stated she was headed that way to help assist residents with lunch. In an observation on 05/15/24 at 12:15 pm, the investigator walked back to the nurse's station and observed the laptop had been left up and unlocked again on Resident #3's face sheet. Across from RN A's desk, there was another laptop that was folded down, but not closed. There was a blue light reflecting on the keyboard and when the investigator pulled the laptop screen up, it was observed that the laptop was left unlocked and was open on the page of Resident #4's MAR. In an interview on 05/19/24 at 12:19 pm with RN A, she is asked should the laptops be locked when the nurses are not at the station. She said that the laptops did not have to be locked when no one was at the nurse's station, but they did have to be flipped down, but not closed. She said that if there was no personal information on the screen and no one came behind the nurses station it would be ok. During an interview on 05/15/24 at 12:19 am with RN A, the DON walked up, and she was asked if it was appropriate for staff to have laptops unlocked with the MAR in view. She replied It was left like that? No, that is not acceptable. I will have to do a reeducation tomorrow. In an interview on 05/20/24 at 2:56 pm with the DON, she stated that the harm in leaving resident information exposed was a HIPAA violation (used to make sure that Personally Identifiable Information gathered in healthcare and insurance companies are protected against fraud and theft, and cannot be disclosed without consent). She explained that she completed an in-service on that incident and she reeducated RN A. Record review of the facility's policy and procedure titled Electronic Protected Health Information Security HIPAA Manual dated June 2019 stated: A. Physical Safeguards a. The facility will work to locate terminal for access to ePHI in secure locations to prevent unauthorized access. i. Computers or other electronic devices will be located in areas that limit access by residents and visitors. ii. When possible, monitors should face away from public view.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 2 of 5 residents (Resident #1 and Resident #2) whose care was reviewed for accidents and supervision. 1. Resident #1 was smoking unsupervised and housed his cigarettes inside of his room. 2. Resident #2 was observed taking a cigarette out of his room before he went outside during the designated smoking hour. These deficient practices could affect residents at the facility who smoked by contributing to burns or serious injuries. Findings Included: 1.Record review of Resident #1's face sheet revealed a sixty-seven-year-old man was admitted to the facility on [DATE]. An admitting diagnosis was acute B chronic obstructive pulmonary disease (COPD, lung disease),. Record review of Resident #1's care plan on 05/20/24 revealed he was a smoker and had the potential for injury related to smoking. Intervention dated on 03/04/24 stated that he was a supervised smoker and an intervention initiated on 04/25/23 (date listed) stated that smoking material was to be maintained by staff. Review of his ADL's dated 04/10/23 revealed he had an ADL self-care deficits and was at risk for further decline in ADL functioning and injury related to impaired cognition, weakness. Record review of Resident #1's MDS dated [DATE] Section C Cognitive patterns revealed a score 11 out of 15 (moderately impaired). 2.Record review of Resident #2's face sheet revealed a fifty-seven-year-old man who was originally admitted to the facility on [DATE]. His admitting diagnoses were acute kidney failure, atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the artery walls), chronic obstructive pulmonary disease (COPD, lung disease), hypertension (high blood pressure), and Type 2 diabetes (chronic condition that happens when you have persistently high blood sugar levels). Record review of Resident #2's care plan on 05/20/24 revealed he was a smoker and had the potential for injury related to smoking. Intervention dated on 03/04/24 stated that he was a supervised smoker and that he was to be informed of the facility's smoking policy and potential consequences of noncompliance (dated 08/04/23). Review of his ADL's dated 08/03/23 revealed he an ADL self-care deficit and was at risk for further decline in ADL functioning and injury related to impaired cognition, Record review of Resident #1's MDS dated [DATE] Section C Cognitive patterns revealed a blank score (score was not accurately completed). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 05/20/24 at 11:00 am, Resident #1 was outside in the designated smoking area smoking a cigarette. There were no other residents outside with him and there were no staff supervising him. In an observation on 05/20/24 at 11:23 am, Resident #2 walked into his room and came out with a cigarette in his left hand. Resident #2 then used his walker to guide himself down the hall and out the door to the designated smoking area. In an observation on 05/20/24 at 11:30 am, Resident #1, Resident #2, and four other residents were observed smoking outside in the designated smoking area. Resident #1 left the smoking area and began to make his way down the hall using his walker back to his room. In an interview on 05/20/24 at 11:32 am with Resident #1, he walked into his room and grabbed his pack of cigarettes and placed one inside of his pocket. He stated that the facility does not let him keep his cigarettes on him, but they do not take them from him either. On the wall inside him room, the smoking times were listed on the wall and displayed that smoking was allowed at 11am, 3pm, and 7pm. When asked if he was supervised when smoking, he stated that he usually goes by himself, and he has never hurt himself while smoking. An interview was attempted in 05/20/24 at 2:16 pm with Resident #2. He was seen in the bed sleeping quietly. In an interview on 05/20/24 at 2:24 pm with CNA B, she stated that residents were not allowed to have cigarettes inside of their rooms. After residents were done smoking, a specified staff member from nursing, housekeeping, or maintenance would collect cigarettes and lighters and place them in a box. This box was secured inside of the nursing closet. She stated that residents were also not allowed to smoke by themselves, and they must be supervised at all times. In an interview on 05/20/24 at 2:56 pm with the DON, she stated she was not aware residents had access to cigarettes in their rooms. She was not sure where they were getting them from because the policy was to collect cigarettes and supplies after every smoke break. She suggested Resident #1 and Resident #2 may have gotten their cigarettes from pass (approved time to leave the facility). She stated staff have educated residents, preformed smoking assessments, and they discussed smoking policies during resident council. She explained that the harm in residents keeping their own cigarettes was a safety concern. Record review of the facilities Policies and Procedures subsection Safe Smoking, dated 03/24 stated: a. Staff members maintain all smoking materials as appropriate for the resident. Staff members will distribute smoking materials to residents at designated smoking times in the designated smoking area. b. Residents who require supervision while smoking will be supervised by an employee throughout the designated smoke break.