

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER Bay Ridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 208 South Utah LA Porte, TX 77571	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561</p> <p>Based on interview and record review, the facility failed to ensure each resident was free from abuse for one (Resident #1) of fifty- one residents reviewed for abuse.</p> <p>The facility failed to prevent the AD from verbally abusing Resident #1. The AD made the statement where I come from snitches get stitches and end up in ditches.</p> <p>This failure could place 51 residents who participate in activities at risk of verbal abuse and decreased quality of life.</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were a cerebral infraction (area of tissue death to the brain), cognitive communication deficit (difficulty with thinking and using language), depression, and COPD (lung disease).</p> <p>Record review of Resident #1's MDS completed [DATE], revealed a BIMS (interview to determine a resident's mental status) score of 14 (cognitively intact).</p> <p>Record review of Resident #2's face sheet dated [DATE] revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were unspecified fracture of lower limb of right femur, cellulitis of left lower limb, cognitive communication deficit (difficulty with thinking and using language), COPD (lung disease), and depression.</p> <p>Record review of Resident #1's MDS 3.0 completed [DATE], revealed a BIMS (interview to determine a resident's mental status) score of 13 (cognitively intact).</p> <p>Record review of the facility's grievance log from January- [DATE] revealed there were not any concerns regarding staff customer service or activities.</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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 12:57 pm with the SW, she stated that she attended a care plan meeting for Resident #1 on [DATE]. In attendance were the DON, Admin, and members of Resident #1's family. During the meeting the resident stated that she felt that the AD did not like her and had not liked her since her admission in February of 2024. She stated that earlier that week, the activities director told her Snitches get stitches and end up in ditches. That was the first time any of the staff had heard that and they immediately asked her what happened. The Administrator intervened and told her she would speak to her in private after the care plan meeting. The police were called on site and Resident #1 and the AD were asked to give statements. The psychiatrist was also requested at the facility and arrived the following day on [DATE]. The SW said she followed up with the resident later on [DATE] and asked her how she was feeling. Resident #1 stated that she felt threatened when she heard AD make the comment about stitches. Although she currently felt stressed, she felt better now that everything was out in the open and she was happy that staff were aware so that they could keep an eye on the AD and the resident. The SW stated that the AD had been suspended while the investigation was ongoing and that she had not received any grievances or complaints about the AD. In addition to activities, the AD was head of the resident council, and she would document any grievances from residents and give them to the Admin or DON. The SW stated that she had received training on abuse and neglect the week prior and on [DATE].</p> <p>In an interview on [DATE] at 1:13 pm, Resident #1 stated that she had been at the facility for about a month and although residents at the facility went on a weekly store outing, she had not been on one since she had arrived. She explained that every time she would ask the AD, there would be an excuse such as the bus was full and she had already picked who she wanted to ride with her. The van the facility used was only able to accommodate so many wheelchairs, but the AD would never schedule her for a different outing/day. On [DATE], Resident #1 told the DON about that, and the DON said she would speak with the AD and make sure that she could go on the next one. Following that, Resident #1 and Resident #2 were sitting in the designated smoking area outside of the facility. The AD came outside and stated Where I come from, snitches get stitches and wind up in ditches. Resident #1 was not sure if this was directed to her but it was said within earshot. Resident #1 felt like the AD was always on her case because Resident #1 did not prefer the activities she provided. On [DATE], the resident was in the hallway and CNA A, who is related to the AD, got too close to her wheelchair and she accidentally ran over her foot. She stated I told her (CNA A) a thousand times do not get too close to my wheelchair and she put her foot directly in front of my wheel. I didn't move fast enough and her foot got caught underneath my wheelchair. CNA A let out a loud scream and staff came to assist her. Resident #1 expressed that the AD was taunting her the following day and told her that she was going to sue the facility and Resident #1. Resident #1 responded that she did not have anything to sue for and the only reason that she was at the facility was because they accepted her insurance. She stated that that along with the comment about snitches, was her last straw and prompted her family to bring up these issues in the care plan meeting. She stated that she did not tell anyone in the facility because she did not want and problems and only wanted piece. She revealed that after her family brought up with situation in the care plan meeting, she felt a sense of relief that the behaviors from the AD were out in the open and that now people from the facility could be watch both the AD and herself.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] with the LVN at 2:23 pm, she stated that she saw when Resident #1's electric wheelchair was on CNA A's foot mid-day on [DATE]. She explained that Resident #1 did not have good peripheral vision and explained that she did not respond fast because she was not a quick thinker. She believed that it truly was an accident and did not feel that Resident #1 intentionally ran over the CNA's foot. The CNA left the facility and went to the hospital and came back on [DATE] wearing a boot on her foot.</p> <p>In an interview on [DATE] at 03:02 pm with the AD, she explained that every month she would take , d+[DATE] residents on a trip of their choice around the county, but she also had to account for the amount of staff who must go to help with residents in wheelchairs. When asked if she kept a list, she stated that she did write it down, but she did not keep a list per visit and she apologized for not keeping up with it. She stated that on Monday's, she would get a list of things that residents requested from the store and take one person to accompany her. She stated that she absolutely did not make the statement where I come from snitches get stitches and end up in ditches and she had never taunted Resident #1. The AD said that she did not know why Resident #1 had a vendetta against her and assumed that her problem could be that Resident #1 wanted to smoke in areas outside of the designated smoking area. During a monthly outing, The AD caught Resident #2 eating a cake inside of the grocery store and she told her that she could go to jail for that. When they returned, she reported Resident #2 to the facility. The AD believed that Residents #1 and #2 were targeting her. When asked if she had been outside with Resident #1 in the designated smoking area, she said maybe, because she was always out there.</p> <p>An attempted interview call was made to CNA A on [DATE] at 03:22 pm. She did not answer and a voicemail was left requesting a call back.</p> <p>In an interview on [DATE] at 03:21 pm with the DON, she recounted that her first time hearing of the behavior between the AD and Resident #1 was at the care plan meeting on [DATE]. A family member of Resident #1 was first to bring it up and Resident #1 stated that the AD said something regarding snitches getting stitches and ending up in ditches. After that was revealed, the staff quickly finished the care plan meeting, and the Administrator began to investigate it because she knew it would be a reportable offense. She had no knowledge of their being any type of static between the AD and Resident #1. She stated that the facility's administration always spoke about abuse and neglect with staff and told the residents that they would want to know those things.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 03:50 pm with the Admin, she revealed that a care plan meeting was scheduled with Resident #1 and her family because there were some challenges with her following the facility rules. The IDT discussed the idea of switching the resident from a motorized to a mechanical wheelchair and the family understood. When a member of the family mentioned the statement of snitches, the Admin told them that the statement sounded like verbal abuse and a threat. The family stated that they did not believe that Resident #1 was threatened by the AD, but they did want the facility to follow up on the process, which would be to contact the state and the police. The Admin revealed that a witness to the incident was Resident #2, and she stated that the AD did not say it directly to her Resident #1, but she did say it in the air and labeled it as trash or street talk. When the police arrived, Resident #1 was questioned and she stated that she did not want to press charges, however the Admin felt that she needed to be more professional and they always covered topics like customer service in the all staff meeting. The police came to the facility on the afternoon of [DATE] and interviewed Resident #1, Resident #2, and the AD. Resident #1 did not state that the statement from the AD was made directly to her, but she felt strongly that the AD was talking indirectly about her when she said it. Resident #1 told the police that she did not want to press charges, but she was glad that this situation was now in the open. The AD was suspended from work pending the outcome of the investigation and Admin had scheduled an all staff meeting on [DATE] to begin in-services. She stated that a solution going forward may be to separate staff and resident smoking areas and she would be terminating the AD after she discussed the findings with the surveyor after their investigation. When the Admin spoke about the incident where Resident #1 ran over CNA A's foot, she stated that she did not do it on purpose, but she thought that the AD probably thought it was something more serious because her CNA A was in her 70's. After the incident, the facility felt they should transition Resident #1 to a manuell wheelchair.</p> <p>In an interview on [DATE] at 09:30 am, Resident #2 said that the outing last week to the store was horrible. She explained that she ate a banana in the grocery store and that she was from a small town and that was what they did. The AD was very loud when she confronted her and said that's theft!. She stated that made her feel bad and she explained that she had another banana in her basket to weigh at the register so she could pay for the one she ate prior to being confronted. Resident #2 felt that the AD did not speak kindly. She received a phone call during this interview and it was continued at a later time.</p> <p>In an interview on [DATE] at 10:11 am with CNA B, she stated that she had heard the AD say y'all asses are ungrateful. I spent my money on these gifts and y'all don't like it after a game of bingo with the Residents. She explained that the AD had prizes like popcorn, chips, and candy that she purchased out of pocket, but it still did not give her the right to speak like that. Resident #1 was called ungrateful because she had won a headband in bingo, but because Resident #1 only had one functioning arm, she could not use it. CNA B stated that she witnessed the incident between the AD and Resident #1. Afterwards, CNA B stated that she told Resident #1 that she needed to report that incident to the abuse coordinator (Admin). CNA B stated the outburst exhibited by the AD was not an isolated incident and that she believed some residents were afraid.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In the follow up interview with Resident #2 on [DATE] at 10:26 am, she recapped that when the AD made the comment about snitches lie in ditches, she had come to the smoking area after Resident #1 and Resident #2 were outside. Resident #2 referred to her comment as slang and said that it didn't bother her, she would just take her comments and try to keep her mouth shut. She stated that she thought that the AD came outside and made the comment because she heard from another employee that Resident #1 told on her to the DON. She felt that the DON did not make the statement directly to Resident #1 and herself, but she said it aloud while they were gathered in the facility smoking area and they were the only 3 people outside. Resident #2 also added that the AD would tell the residents what she bought for bingo, and she would say that she would not ever spend a dime on them. Resident #2 stated that it was not the residents' problem, to have to worry about the finances of stuff, but they heard thenAD speak about it anyways. She recalled a time that Resident #1 asked her what time bingo was and the AD replied There won't be none because I'm tired of spending money around here. The AD also was real ugly about letting Resident #1 know that she was responsible for CNA's foot. Resident #2 stated that We have already enough heck going on. It makes me feel like wow, this is the authority, this is the leadership up here. It makes me feel like Bologna. It's not good to live up here.</p> <p>In a follow up interview on [DATE] at 12:08 pm, CNA B was asked why she did not report any behaviors from the AD to the Admin. She stated that she was honestly in shock when she heard the AD say it. She did not know how the AD would come at her because she was rude and she wanted to avoid the confrontation. She admitted that she was supposed to tell the Admin and she felt comfortable with telling her things like that. She stated that when she heard the comment made by the AD, The steps would be to not address her but follow the chain of command and go to the abuse coordinator (Admin). After, the Admin would do an investigation. She did not feel like the AD would necessarily retaliate, but there would be some kind of tension. She said she knew she should have reported it, but she liked to come to work where things were peaceful and everybody got along.</p> <p>In a follow up interview on [DATE] at 12:15 pm with the Admin, she told the surveyor that she would be writing up CNA B for not informing her about the incident she overheard with the AD and Resident #1. Admin stated that staff talked about abuse and neglect often, and they recently had an in-service on abuse and neglect and how to report it to the abuse and neglect coordinator (Admin). She said that AD and CNA B's behavior was unacceptable. Admin also stated that she had been working at that facility for over [AGE] years and she promoted a see something, say something policy. She also stated that she had no knowledge that the AD had spoken to Resident #2 in a way that made her feel bad when she was at the grocery store during the facility's last outing.</p> <p>Record review of an in-service Titled Resident to Resident Altercation, Verbal Abuse and Neglect dated [DATE] revealed that CNA A, CNA B, and the AD were not in attendance.</p> <p>Record review of an in-service titled Abuse, neglect, workplace violence dated [DATE] revealed CNA A and the AD were in attendance.</p> <p>Record review of the AD's employee personnel file of her nurse aid registry documents revealed that her license expired on [DATE]. The Admin provided an extension document from the TX Nurse Aide registry that revealed HHSC is extending a grace period for all nurse aides to all users time to learn and understand the new credentialing systems. All Nurse aides approvals active on [DATE], will be considered active until [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Abuse Prohibition Policy revised [DATE] specified the facility will prohibit neglect, mental or physical abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse.</p> <p>Record review of the facility's policy titled Resident rights, revised February 2021, specified that Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <ul style="list-style-type: none"> a. Be treated with respect, kindness, and dignity. b. Be free from abuse and neglect c. Voice grievances to the facility, or other agencies that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal. d. Have the facility respond to his or her grievances. 		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561</p> <p>Based on interview and record review failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, for one (Resident #1) of fifty- one residents reviewed for abuse.</p> <p>CNA B failed to report verbal abuse from the AD to Resident #1 to the Administrator.</p> <p>This failure could place 51 residents who participate in activities at risk of verbal abuse and decreased quality of life.</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were a cerebral infraction (area of tissue death to the brain), cognitive communication deficit (difficulty with thinking and using language), depression, and COPD (lung disease).</p> <p>Record review of Resident #1's MDS completed [DATE], revealed a BIMS (interview to determine a resident's mental status) score of 14 (cognitively intact).</p> <p>Record review of Resident #2's face sheet dated [DATE] revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were unspecified fracture of lower limb of right femur, cellulitis of left lower limb, cognitive communication deficit (difficulty with thinking and using language), COPD (lung disease), and depression.</p> <p>Record review of Resident #1's MDS 3.0 completed [DATE], revealed a BIMS (interview to determine a resident's mental status) score of 13 (cognitively intact).</p> <p>Record review of the facility's grievance log from January- [DATE] revealed there were not any concerns regarding staff customer service or activities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 12:57 pm with the SW, she stated that she attended a care plan meeting for Resident #1 on [DATE]. In attendance were the DON, Admin, and members of Resident #1's family. During the meeting the resident stated that she felt that the AD did not like her and had not liked her since her admission in February of 2024. She stated that earlier that week, the activities director told her Snitches get stitches and end up in ditches. That was the first time any of the staff had heard that and they immediately asked her what happened. The Administrator intervened and told her she would speak to her in private after the care plan meeting. The police were called on site and Resident #1 and the AD were asked to give statements. The psychiatrist was also requested at the facility and arrived the following day on [DATE]. The SW said she followed up with the resident later on [DATE] and asked her how she was feeling. Resident #1 stated that she felt threatened when she heard AD make the comment about stitches. Although she currently felt stressed, she felt better now that everything was out in the open and she was happy that staff were aware so that they could keep an eye on the AD and the resident. The SW stated that the AD had been suspended while the investigation was ongoing and that she had not received any grievances or complaints about the AD. In addition to activities, the AD was head of the resident council, and she would document any grievances from residents and give them to the Admin or DON. The SW stated that she had received training on abuse and neglect the week prior and on [DATE].</p> <p>In an interview on [DATE] at 1:13 pm, Resident #1 stated that she had been at the facility for about a month and although residents at the facility went on a weekly store outing, she had not been on one since she had arrived. She explained that every time she would ask the AD, there would be an excuse such as the bus was full and she had already picked who she wanted to ride with her. The van the facility used was only able to accommodate so many wheelchairs, but the AD would never schedule her for a different outing/day. On [DATE], Resident #1 told the DON about that, and the DON said she would speak with the AD and make sure that she could go on the next one. Following that, Resident #1 and Resident #2 were sitting in the designated smoking area outside of the facility. The AD came outside and stated Where I come from, snitches get stitches and wind up in ditches. Resident #1 was not sure if this was directed to her but it was said within earshot. Resident #1 felt like the AD was always on her case because Resident #1 did not prefer the activities she provided. On [DATE], the resident was in the hallway and CNA A, who is related to the AD, got too close to her wheelchair and she accidentally ran over her foot. She stated I told her (CNA A) a thousand times do not get too close to my wheelchair and she put her foot directly in front of my wheel. I didn't move fast enough and her foot got caught underneath my wheelchair. CNA A let out a loud scream and staff came to assist her. Resident #1 expressed that the AD was taunting her the following day and told her that she was going to sue the facility and Resident #1. Resident #1 responded that she did not have anything to sue for and the only reason that she was at the facility was because they accepted her insurance. She stated that that along with the comment about snitches, was her last straw and prompted her family to bring up these issues in the care plan meeting. She stated that she did not tell anyone in the facility because she did not want and problems and only wanted piece. She revealed that after her family brought up with situation in the care plan meeting, she felt a sense of relief that the behaviors from the AD were out in the open and that now people from the facility could be watch both the AD and herself.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] with the LVN at 2:23 pm, she stated that she saw when Resident #1's electric wheelchair was on CNA A's foot mid-day on [DATE]. She explained that Resident #1 did not have good peripheral vision and explained that she did not respond fast because she was not a quick thinker. She believed that it truly was an accident and did not feel that Resident #1 intentionally ran over the CNA's foot. The CNA left the facility and went to the hospital and came back on [DATE] wearing a boot on her foot.</p> <p>In an interview on [DATE] at 03:02 pm with the AD, she explained that every month she would take , d+[DATE] residents on a trip of their choice around the county, but she also had to account for the amount of staff who must go to help with residents in wheelchairs. When asked if she kept a list, she stated that she did write it down, but she did not keep a list per visit and she apologized for not keeping up with it. She stated that on Monday's, she would get a list of things that residents requested from the store and take one person to accompany her. She stated that she absolutely did not make the statement where I come from snitches get stitches and end up in ditches and she had never taunted Resident #1. The AD said that she did not know why Resident #1 had a vendetta against her and assumed that her problem could be that Resident #1 wanted to smoke in areas outside of the designated smoking area. During a monthly outing, The AD caught Resident #2 eating a cake inside of the grocery store and she told her that she could go to jail for that. When they returned, she reported Resident #2 to the facility. The AD believed that Residents #1 and #2 were targeting her. When asked if she had been outside with Resident #1 in the designated smoking area, she said maybe, because she was always out there.</p> <p>An attempted interview call was made to CNA A on [DATE] at 03:22 pm. She did not answer and a voicemail was left requesting a call back.</p> <p>In an interview on [DATE] at 03:21 pm with the DON, she recounted that her first time hearing of the behavior between the AD and Resident #1 was at the care plan meeting on [DATE]. A family member of Resident #1 was first to bring it up and Resident #1 stated that the AD said something regarding snitches getting stitches and ending up in ditches. After that was revealed, the staff quickly finished the care plan meeting, and the Administrator began to investigate it because she knew it would be a reportable offense. She had no knowledge of their being any type of static between the AD and Resident #1. She stated that the facility's administration always spoke about abuse and neglect with staff and told the residents that they would want to know those things.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER Bay Ridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 208 South Utah LA Porte, TX 77571	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 03:50 pm with the Admin, she revealed that a care plan meeting was scheduled with Resident #1 and her family because there were some challenges with her following the facility rules. The IDT discussed the idea of switching the resident from a motorized to a mechanical wheelchair and the family understood. When a member of the family mentioned the statement of snitches, the Admin told them that the statement sounded like verbal abuse and a threat. The family stated that they did not believe that Resident #1 was threatened by the AD, but they did want the facility to follow up on the process, which would be to contact the state and the police. The Admin revealed that a witness to the incident was Resident #2, and she stated that the AD did not say it directly to her Resident #1, but she did say it in the air and labeled it as trash or street talk. When the police arrived, Resident #1 was questioned and she stated that she did not want to press charges, however the Admin felt that she needed to be more professional and they always covered topics like customer service in the all staff meeting. The police came to the facility on the afternoon of [DATE] and interviewed Resident #1, Resident #2, and the AD. Resident #1 did not state that the statement from the AD was made directly to her, but she felt strongly that the AD was talking indirectly about her when she said it. Resident #1 told the police that she did not want to press charges, but she was glad that this situation was now in the open. The AD was suspended from work pending the outcome of the investigation and Admin had scheduled an all staff meeting on [DATE] to begin in-services. She stated that a solution going forward may be to separate staff and resident smoking areas. When the Admin spoke about the incident where Resident #1 ran over CNA A's foot, she stated that she did not do it on purpose, but she thought that the AD probably thought it was something more serious because her CNA A was in her 70's. After the incident, the facility felt they should transition Resident #1 to a manual wheelchair.</p> <p>In an interview on [DATE] at 09:30 am, Resident #2 said that the outing last week to the store was horrible. She explained that she ate a banana in the grocery store and that she was from a small town and that was what they did. The AD was very loud when she confronted her and said that's theft!. She stated that made her feel bad and she explained that she had another banana in her basket to weigh at the register so she could pay for the one she ate prior to being confronted. Resident #2 felt that the AD did not speak kindly. She received a phone call during this interview and it was continued at a later time.</p> <p>In an interview on [DATE] at 10:11 am with CNA B, she stated that she had heard the AD say y'all asses are ungrateful. I spent my money on these gifts and y'all don't like it after a game of bingo with the Residents. She explained that the AD had prizes like popcorn, chips, and candy that she purchased out of pocket, but it still did not give her the right to speak like that. Resident #1 was called ungrateful because she had won a headband in bingo, but because Resident #1 only had one functioning arm, she could not use it. CNA B stated that she witnessed the incident between the AD and Resident #1. Afterwards, CNA B stated that she told Resident #1 that she needed to report that incident to the abuse coordinator (Admin). CNA B stated the outburst exhibited by the AD was not an isolated incident and that she believed some residents were afraid.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In the follow up interview with Resident #2 on [DATE] at 10:26 am, she recapped that when the AD made the comment about snitches lie in ditches, she had come to the smoking area after Resident #1 and Resident #2 were outside. Resident #2 referred to her comment as slang and said that it didn't bother her, she would just take her comments and try to keep her mouth shut. She stated that she thought that the AD came outside and made the comment because she heard from another employee that Resident #1 told on her to the DON. She felt that the DON did not make the statement directly to Resident #1 and herself, but she said it aloud while they were gathered in the facility smoking area and they were the only 3 people outside. Resident #2 also added that the AD would tell the residents what she bought for bingo, and she would say that she would not ever spend a dime on them. Resident #2 stated that it was not the residents' problem, to have to worry about the finances of stuff, but they heard thenAD speak about it anyways. She recalled a time that Resident #1 asked her what time bingo was and the AD replied There won't be none because I'm tired of spending money around here. The AD also was real ugly about letting Resident #1 know that she was responsible for CNA's foot. Resident #2 stated that We have already enough heck going on. It makes me feel like wow, this is the authority, this is the leadership up here. It makes me feel like Bologna. It's not good to live up here.</p> <p>In a follow up interview on [DATE] at 12:08 pm, CNA B was asked why she did not report any behaviors from the AD to the Admin. She stated that she was honestly in shock when she heard the AD say it. She did not know how the AD would come at her because she was rude and she wanted to avoid the confrontation. She admitted that she was supposed to tell the Admin and she felt comfortable with telling her things like that. She stated that when she heard the comment made by the AD, The steps would be to not address her but follow the chain of command and go to the abuse coordinator (Admin). After, the Admin would do an investigation. She did not feel like the AD would necessarily retaliate, but there would be some kind of tension. She said she knew she should have reported it, but she liked to come to work where things were peaceful and everybody got along.</p> <p>In a follow up interview on [DATE] at 12:15 pm with the Admin, she told the surveyor that she would be writing up CNA B for not informing her about the incident she overheard with the AD and Resident #1. Admin stated that staff talked about abuse and neglect often, and they recently had an inservice on abuse and neglect and how to report it to the abuse and neglect coordinator (Admin). She said that AD and CNA B's behavior was unacceptable. Admin also stated that she had been working at that facility for over [AGE] years and she promoted a see something, say something policy.</p> <p>Record review of an in-service Titled Resident to Resident Altercation, Verbal Abuse and Neglect dated [DATE] revealed that CNA A, CNA B, and the AD were not in attendance.</p> <p>Record review of an in-service titled Abuse, neglect, workplace violence dated [DATE] revealed CNA A and the AD were in attendance.</p> <p>Record review of the AD's employee personnel file of her nurse aid registry documents revealed that her license expired on [DATE]. The Admin provided an extension document from the TX Nurse Aide registry that revealed HHSC is extending a grace period for all nurse aides to all users time to learn and understand the new credentialing systems. All Nurse aides approvals active on [DATE], will be considered active until [DATE].</p> <p>Record review of the facility's Abuse Prohibition Policy revised [DATE] specified the facility will prohibit neglect, mental or physical abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled Resident rights, revised February 2021, specified that Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <ul style="list-style-type: none"> a. Be treated with respect, kindness, and dignity. b. Be free from abuse and neglect c. Voice grievances to the facility, or other agencies that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal. d. Have the facility respond to his or her grievances.