

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  04/15/2024
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 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>45328</p> <p>Based on observations, interviews, and records reviewed, the facility failed to provide sufficient support personnel to carry out the functions of the food and nutrition service safely and effectively for 1 of 1 kitchen reviewed for dietary services.</p> <p>-The facility failed to provide sufficient dietary staffing for breakfast on 03/29/24.</p> <p>This failure could place residents at risk of not receiving meals at designated mealtimes and a diminished quality of life.</p> <p>The findings included:</p> <p>Observation and interview on 04/01/24 at 11:41 a.m., revealed Resident #3 was lying in bed. She said last Saturday, 03/30/24, or Friday, 03/29/24, they had kolaches and donuts for breakfast. She said she usually ate cereal for breakfast, but it was something she could eat and did not have any concerns about what was served.</p> <p>Observation and interview on 04/03/24 at 3:49 p.m., revealed Resident #6 was lying in bed. She said she had been feeling under the weather since she had returned from the hospital. She said the facility served donuts and kolaches last Friday, 03/29/24, for breakfast and she had enough to eat. She said it was an isolated incident, the Dietary Manager was on suspension, and it was corrected the next day. She said she asked questions about it because she was the Resident Counsel President.</p> <p>In an interview on 04/01/24 at 2:40 p.m., CNA B said she worked 6:00 a.m. to 3:00 p.m. on Friday 03/29/24. She said she believed that was the day they had to order breakfast for the residents. She said she texted the Administrator, DON, and ADON at 7:19 a.m. to let them know there was no one in the kitchen. She said she told the Charge Nurse there was no dietary staff at the facility and said the Charge Nurse called the DON. She said kolaches and donuts were ordered for the residents.</p> <p>In an interview on 04/01/24 at 4:02 p.m., the ADON, said there was no dietary staff on 03/29/24 to make breakfast. She said the facility ordered kolaches and donuts for the residents to eat. She said she was not notified about the dietary staff not showing up and found out that morning when she arrived to work at 8:07 a.m. She said she did not know what happened to the dietary staff.</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 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/03/24 at 9:06 a.m., the DON said she was notified by telephone and text message, a little before 7:30 a.m. on 3/29/24 by the Charge Nurse, telling her that no one had shown up in the kitchen yet. She said after she was notified, she called the Administrator, and the Administrator called the Corporate Regional Nurse to let her know. She said the Corporate Regional Nurse said to go ahead and order breakfast. She said breakfast was ordered and delivered to the building. She said she was told they had delivered donuts, kolaches, oatmeal, and did not remember if they ordered cereal or got the cereal from the kitchen. She said the only conclusion she could come to about the dietary staff was there was a no call, no show. She said from there the dietary staff was called. She said if dietary staff were not at the facility to make breakfast, then it was not prepared on time and could come out late.</p> <p>In an interview on 04/03/24 at 9:13 a.m., Dietary Aide A said she was scheduled to work on Friday, 03/29/24, in the afternoon from 1:00 p.m. to 7:30 p.m. She said the Administrator called her first, between 7:00 a.m. and 7:30 a.m., but she did not answer the call. She said CNA A then called her at approximately at 8:00 a.m. and asked her to come in to work because there was no cook or tray aide at the facility. She said she told CNA A she would call [NAME] A so someone could be there to cook. She said she called [NAME] A right after she was called and asked her to come to work because there were no workers in the kitchen that showed up. She said she arrived at the facility at approximately 9:00 a.m. She said when she arrived at the facility [NAME] A was already there. She said they did not have to make breakfast that morning because she thinks they bought breakfast for the residents. She said she did not know what happened to the morning kitchen staff and that Dietary Aide B was scheduled to work that morning in the kitchen.</p> <p>A telephone interview on 04/03/24 at 9:51 a.m., with Dietary Aide B was attempted. The call was answered but then disconnected. A text message was sent at 9:52 a.m. requesting a return phone call.</p> <p>In an interview on 04/03/24 at 9:58 a.m., the Dietary Manager said she worked Monday through Friday, from 6:00 a.m. to 2:00 p.m. and was responsible for making the dietary aide schedule. She said on Thursday, 03/28/24, at approximately 2:25 p.m. she was placed on a 3-day suspension. She said the dietary staff schedule for that week had already been made. She said [NAME] A told her she could not work on Fridays, and some other days, on the previous day, Thursday, 03/28/24, between 2:00 p.m. and 2:30 p.m. She said Dietary Aide B was supposed to work Friday, 03/29/24, from 6:00 a.m. to 1:30 p.m., and on Saturday and Sunday from 6:00 a.m. to 7:30 p.m. She said Dietary Aide B sent her a text message Friday morning, 3/29/24, at approximately 8:00 a.m. telling her that she quit. She said she did not let management, or the workers know because she was on suspension.</p> <p>In an interview on 04/03/24 at 11:10 a.m., the Administrator said the dietary manager had been suspended on Thursday, 03/28/24, late in the afternoon and realized then that the Dietary Manager and Dietary Aide B was scheduled to work on Friday, 03/29/24. She said she called the Dietary Manager to let her know that she noticed they were scheduled to work. She said the Dietary Manager said not to worry, that she already notified her staff, and people would be in place. She said the Charge Nurse called the DON around 7:20 a.m. but she was not reached until around 7:40 a.m. She said she immediately tried to call [NAME] B but was unable to reach her. She said she then called the Corporate Regional Nurse at approximately 7:46 a.m. who told her to order food for residents. She said food was ordered at approximately 7:57 a.m. She said kolaches, donuts, and a separate order of apple juice, orange juice, and oatmeal was made. She said Dietary Aide B was a no call/no show and was terminated. She said she was told by the Dietary Manager, yesterday, 04/02/24 that Dietary Aide B notified her that she quit but she did not know what day she told the Dietary Manager.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/03/24 at 3:33 p.m., revealed Resident #4 said he was doing pretty good. He said he was able to eat the donuts and kolaches that were served this past week for breakfast and did not have any trouble eating.</p> <p>Interview on 04/03/24 at 3:38 p.m., revealed Resident #5 said she was doing okay. She said they served donuts and kolaches this past week, 03/29/24, because there was no staff in the kitchen to make breakfast, because no one showed up. She said she was able to eat the food without difficulty and that it was enough for her.</p> <p>In an interview on 04/15/24 at 10:55 a.m., [NAME] A said she was not scheduled to work on Friday, 03/29/24. She said she was off that day, but Dietary Aide A called her at approximately 8:00 a.m. and asked her if she could come to work and mentioned to her that no one showed up to work in the kitchen. She said she arrived at the facility at approximately 9:00 a.m. She said she was the first kitchen staff to arrive. She said she did not have to make breakfast that morning.</p> <p>Record review of time punch cards for all of the dietary staff on 03/29/24, revealed [NAME] A clocked in at 9:07 a.m., [NAME] B clocked in at 1:13 p.m., and Dietary Aide A clocked in at 9:28 a.m.</p> <p>Record review of the facility's policy titled Staffing, revised October 2017, read in part .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment .3. Other support services (e.g., dietary .) are also staffed to ensure that resident needs are met .</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45328</p> <p>Based on interview and record review, the facility failed to ensure each resident received and was provided food prepared in a form designed to meet individual needs for 2 (Resident #1 and Resident #2) of 5 residents reviewed for food preparation.</p> <p>-The facility failed to ensure Resident #1 and #2 received a pureed diet as ordered by the physician.</p> <p>This failure could place residents at risk for poor intake, unmet nutritional needs, choking, and aspiration (when food or drinks enter the lungs).</p> <p>The findings included:</p> <p>Record review of Resident #1's Admission Record, dated 04/05/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included neuroleptic induced parkinsonism (condition where parkinsonian symptoms occur as a side effect of taking neuroleptic drugs), dysphagia (difficulty in swallowing) following unspecified cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain), dysphagia oropharyngeal phase (first stage of swallowing), and other dysphagia.</p> <p>Record review of Resident #1's physician orders, undated, read in part .enhanced diet, pureed texture, thin consistency, fortified meal plan, ordered 12/29/23, start 12/29/23 .</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 03/06/24, revealed the BIMS was not completed as resident was rarely/never understood. Further review revealed he required substantial/maximal assistance with feeding. Section K0520, 3. While a Resident, C. Mechanical altered diet and D. Therapeutic diet were checked.</p> <p>Record review of Resident #1's, undated, care plan revealed he had an ADL self-care performance deficit and required extensive assistance with eating. The resident was on aspiration precautions related to history of Dysphagia and interventions included diet to be followed as prescribed.</p> <p>Record review of Resident #2's Admission Record, dated 04/05/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease (type of dementia that effects memory, thinking, and behavior) with early onset, Wernicke's encephalopathy (type of brain injury that occurs due to a thiamine deficiency), hypertensive heart disease (group of heart conditions caused by high blood pressure), and increased secretion of gastrin (production and release of hormone made by digestive system).</p> <p>Record review of Resident #2's physician orders, undated, read in part .NAS diet, pureed texture, nectar thickened consistency, pleasure feed only for dysphasia, ordered 03/03/24, start 03/03/24 .</p> <p>(continued on next page)</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Quarterly MDS assessment, dated 02/15/24, revealed the BIMS was not completed as resident was rarely/never understood. Further review revealed he was dependent with feeding. Section K0520, 3. While a Resident, C. Mechanical altered diet and D. Therapeutic diet were checked.</p> <p>Record review of Resident #2's, undated, care plan revealed he had an ADL self-care performance deficit and required extensive one-person assistance with eating. Further review revealed he required a NAS, mechanical soft texture, nectar thickened consistency diet for dysphagia and interventions included to provide and serve diet as ordered and RD to evaluate and make diet change recommendations PRN, date initiated/created: 05/10/23 and revision on 08/08/23.</p> <p>Observation and interview on 04/01/24 at 12:47 a.m., revealed smothered chicken, lemon rice, chateau vegetables, dinner roll, whole milk, water, and bread pudding was on the lunch menu. Residents #1 and #2 ate their meal in the dining room. Both residents were served the correct pureed food items.</p> <p>Observation and interview on 04/03/24 at 10:50 a.m., revealed Resident #1 was lying in bed watching television. He said he was doing alright. He said he did not remember having oatmeal for breakfast or if they ordered donuts and kolaches this past week on Friday, 03/29/24.</p> <p>In an interview on 04/01/24 at 2:40 p.m., CNA B said she worked 6:00 a.m. to 3:00 p.m. on Friday, 03/29/24. She said she believed that was the day they had to order breakfast for the residents. She said she texted the Administrator, DON, and ADON at 7:19 a.m. to let them know that there was no one in the kitchen. She said she also told the Charge Nurse that there was no dietary staff at the facility and said the Charge Nurse called the DON. She said kolaches and donuts were ordered for the residents and a resident's family member brought a jug of apple and orange juice. She said she believed the ADON arrived at approximately 8 a.m. and opened the kitchen door. She said kolaches and donuts were served to the residents who were not on a special diet. She said nothing was ordered for the residents who were on a pureed diet. She said as far as she remembered, Residents #1 and #2 were the only residents who were on a pureed diet. She said she went to the kitchen and made 6 bowls of oatmeal and grabbed some pre-made orange juice, milk, and water. She said she asked the Charge Nurse if Residents #1 and #2 could have the oatmeal to eat and the orange juice, milk, and water to drink and she said yes. She said she stayed in the dining room during breakfast time and fed Resident #1. She said residents on a pureed diet who received the wrong type of foods to eat could aspirate, have a hard time chewing, and/or difficulty swallowing.</p> <p>In an interview on 04/01/24 at 3:39 p.m., Nurse A said she worked 6:00 a.m. to 6:00 p.m. on 03/29/24. She said kolaches and donuts were ordered for breakfast. She said oatmeal, cold cereal, milk, and juice was also available for the residents. She said the kitchen staff arrived after they finished with breakfast and said she did not know what happened with them. She said the Administrator and DON were notified, she did not know by whom, but said she was going to call them, but was told they already called. She said she did not pass breakfast that morning. She said she was given 2 bowls of oatmeal, thickened juice, a thickened strawberry health shake, and thickened water for Resident #2. She said the residents who were on a mechanical soft diet got cereal and oatmeal. She said the oatmeal was already in a pureed consistency just the way it was made. She said she knew this from her [AGE] years of nursing and looking at a pureed consistency. She said the oatmeal was really, really, soft, and easy for the residents to swallow. She said if a resident was on a pureed diet and got the wrong foods to eat, they could choke if it they were on the diet for chewing and/or swallowing.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/01/24 at 4:02 p.m., ADON, said there was no dietary staff on 03/29/24 to make breakfast. She said the facility ordered kolaches and donuts for the residents to eat. She said apple juice oatmeal, cream of wheat, dry cereal, and premade water, milk, orange juice, thickened liquids, and some kind of custard was provided to the residents who were on a pureed diet. She said CNA B made the oatmeal that morning. She said Residents #1 and #2 were on a pureed diet. She said those 2 residents may have been served oatmeal, custard, and their liquid drinks. She said Resident #1 was on thin liquids and Resident #2 was on nectar thickened. She said she did not know what happened to the dietary staff. She said Resident #2 got 2 bowls of oatmeal. She said she believed everyone got everything they were supposed to. She said if a resident was given the wrong food to eat, they could aspirate.</p> <p>In an interview on 04/03/24 at 9:06 a.m., the DON said she was notified by telephone and text message a little before 7:30 a.m. on 3/29/24 by the Charge Nurse telling her that no one had shown up in the kitchen yet. She said after she was notified, she called the Administrator, and the Administrator called the Regional Nurse [NAME] to let her know. She said [NAME] said to go ahead and order breakfast. She said breakfast was ordered and delivered to the building. She said she was told they had delivered donuts, kolaches, oatmeal, and did not remember if they ordered cereal or got the cereal from the kitchen. She said Residents #1 and #2 were on a pureed diet. She said she did not know what they were served and did not ask.</p> <p>In an interview on 04/03/24 at 9:58 a.m., the Dietary Manager said she worked Monday through Friday, from 6:00 a.m. to 2:00 p.m. and was responsible for making the dietary aide schedule. She said on Thursday, 03/28/24, at approximately 2:25 p.m. she was placed on a 3-day suspension. She said the dietary staff schedule for that week had already been made. She said [NAME] A told her she could not work on Fridays, and some other days, on the previous day, Thursday, 03/28/24, between 2:00 p.m. and 2:30 p.m. She said Dietary Aide B was supposed to work Friday, 03/29/24, from 6:00 a.m. to 1:30 p.m., and on Saturday and Sunday from 6:00 a.m. to 7:30 p.m. She said Dietary Aide B sent her a text message Friday morning, 3/29/24, at approximately 8:00 a.m. telling her that she quit. She said she did not let management, or the workers know because she was on suspension. She said oatmeal did not need to be pureed. She said it was all about preparation. She said by preparation she meant that the box directions needed to be followed to a T. She said Residents #1 and #2 were on a pureed diet.</p> <p>In a telephone interview on 04/03/24 at 10:35 a.m., the Dietician said she had been contracted since November 2023 and spent 10 hours per month at the facility. She said she would not think oatmeal was in its pureed form. She said it should be put into a blender and water should be added until it formed the right consistency that the resident needed. She said Residents # 1 and #2 should be eating pureed oatmeal because regular oatmeal was too thick. She said eating regular oatmeal could lead to choking, food getting into their lungs, and/or more significant food scenarios.</p> <p>Record review of the facility's policy titled Therapeutic Diets, reviewed [DATE], read in part . a therapeutic diet is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet or to alter the texture of a diet .</p> <p>Record review of the facility's policy titled Food and Nutrition Services, dated October 2022, read in part . each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs .</p>		