STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675052	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Ridge Healthcare Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision to prevent accidents for 1 out of 3 residents (Resident #1) reviewed for adequate supervision.The facility failed to ensure that each resident receives adequate supervision and assistive devices to prevent accidentsThis noncompliance was identified as Past Non-Compliance Immediate Jeopardy (IJ). The IJ began on 8/21/25 and ended on 8/31/25. The facility corrected the noncompliance by having implemented actions that corrected the non-compliance prior to surveyor entrance. This failure could expose residents living in the facility to safety and accident hazards.Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that include Anoxic Brain Damage (a brain injury that occurs when the brain is deprived of oxygen, which can lead to confusion, speech and vision problems, loss of consciousness, and long-term issues like tremors, memory loss, and difficulty with motor skills) Schizoaffective (a severe mental health condition that combines symptoms of schizophrenia, such as hallucinations and delusions, with a mood disorder like bipolar disorder or depression) and Anxiety Disorder (any of a group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats, leading to altered behavior and often to physical symptoms such as increased heart rate or muscle tension). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIM score of 2 which indicated severe cognitive impairment. Resident #1 could ambulate without assistance with any mobility devices. Resident #1 uses a Wander/elopement alarm daily. Record review of Resident #1's care plan dated 8/7/24 revised on 8/25/25 addressed wandering, read I have been evaluated as a wandering risk r/t decreased safety awareness, confusion and wandering behavior and require the use of a wander guard for safety. Interventions included: I will remain free of injuries associated with wandering behaviors through this review period and check my location frequently. Resident #1's initial wandering evaluation conducted on 8/5/24 indicated he was not a wandering risk. Record review of Resident #1's nursing progress note dated 8/21/25 written by (staff ID) read @ (at) or around 2300 {11:00 PM}, [city] Police knocked on the door and informed this writer that a young male was looking around and messing with the neighbor's belongings and asked if he is a resident of the facility. This writer informed them yes and returned inside the facility with the resident. Upon assessing resident, no injuries were noted and no s/s of pain and/or distress noted at present time. This writer notified RP and DON. Will cont. to monitor. Record review of the facility incident report dated 8/21/25 read in part.Brief narrative summary of the reportable incident: During night shift rounds resident was observed in bed sleeping at 10:15pm. At 11:05pm resident was at front door awaiting to be let in. Resident had wander guard on at time of incident. Resident returned by the local police was found across the street away from the facility for approximately 20 minutes. Resident assessed and no injuries were noted. Resident #1 placed on one-on-one monitoring. RP DON, Administrator notified. Elopement in-service started immediatelySide Door Code changed immediately. Smoking policy and instruction to ensure door security. Interview on 11/6/25 at 9:57 am with Resident #1's Family Member said was notified that Resident #1 eloped. She said the facility had suggested a transfer to a secure location after the elopement, but she did not want the transfer. Observation and interview on 11/6/25 at 10:40 a.m., Resident #1 lying in his bed awake, groomed and presenting no odors or visible injuries. When asked how he was doing, he said fine. No additional questions, including questions about the elopement, were not answered. Observation and Interview on 11/6/25 at 9:25 a.m., the DON said that through the facility investigation, they found that Resident #1 eloped due to Resident #2 propping the door open when she went out to smoke. She said there was no police report filed that the police officer just brought him back to the facility and the police were contacted by a household across the street. She added that Resident #1 was assessed and had no injuries. She said they placed him on one-on-one monitoring. Educated Resident #2 on propping the doors open and performed audit checks on all residents with wander guards. All staff were in-services on elopements, supervision, and smoking rules. She said that the facility had a meeting and believed there was a PIP but would wait for the Administrator to provide that information. The DON was asked to show the area and route Resident #1 eloped to and the door that was propped open at the time was observed, the route and house that Resident #1 eloped to was directly across the street. Interview with the Administrator on 11/6/25 at 11:15 am, she stated that through the facility investigation, they found that Resident #1 eloped due to Resident #2