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	11/25/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately to the State Survey Agency for Resident #2. - The facility failed to investigate and report (within 2 hours or 24 hours) an incident involving an unwitnessed fall in which Resident #2 sustained a hematoma to the forehead and skin tear to the eyebrow. This failure could place residents at risk of falls not investigated to prevent abuse and neglect.Record review of Resident #2's admission face sheet, dated 10/24/2025, revealed Resident #2 was an [AGE] year-old female admitted on [DATE]. Resident #2's diagnoses included hypertension (high blood pressure), diabetes (high blood sugar), hyperlipidemia (high level of fat in the blood), malnutrition (when the body does not get enough calories, vitamin , minerals and protein), schizophrenia (a chronic mental health condition that impacts a person's thoughts, feeling and behaviors), anxiety disorder (mental health condition characterized by worry, fear and nervousness), depression (mental health condition characterized by feelings of sadness and loss of interest in activities), muscle weakness (loss of muscle strength), and dysphagia (difficulty swallowing). Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 02, indicating Resident #2 was cognitively impaired, indicating the resident's skills for decision making were not intact. For Functional abilities, she was coded: for eating - supervision assistance, for toileting - putting on and taking off footwear, shower/bathe self, upper/lower body dressing, and for personal hygiene she was coded as needing partial/moderate assist, and for bowel and bladder, she was coded as always incontinent. Record review of nurse's notes, dated 10/1/2025, written by LVN B, revealed, .resident found on floor on left side yelling for help. Resident had bleeding under her left side at temple. Resident was assisted to sitting position - vitals taken BP 105/71 P 80 T97.3 Pulse Ox 98 on room air resident assisted to W/C for further evaluation. Hematoma noted to left forehead with small skin tear on left forehead in center of hematoma. Team health notified - spoke with MD- ordered to send to hospital - family notified. 911 called to transport to nearest hospital. Record review of nurses' notes, dated 10/01/2025, written by LVN B, documented. Received resident from hospital on stretcher with two EMTs-BP 105/58-P65-R 14-T 97.3-Noted on forehead a few abrasions on left side of forehead, no active bleeding, scratched over-Resident alert knows where she was at this time. Bed low position and call light within reach-Educated resident to use call light when she attention -Place call to RP will call back again this shift. During an interview on 10/24/2025 at 12:15 pm. the Administrator was asked if there was an incident report for Resident #2, she said she was going to look for it. The Administrator was informed by the surveyor Resident #2 had an unwitnessed fall with hematoma and was sent to the hospital. At that point she said she was going to look for the incident report. In an interview on 10/24/2025 at 2:42 pm with the DON regarding reporting incidents, she said the staff usually reported incidents to her and the Administrator. She said when incidents were reported to her, she would inform the Administrator. She said the Administrator would investigate and report it to the state. She said unwitnessed falls should be investigated and reported if there were injuries and if the resident was unable to say what caused the fall. Further interview on 10/28/2025 at 10:30 am with the Administrator she said the incident was not investigated and reported. She said she took full responsibility for not investigating and reporting the incident in the 2 hours or 24 hours' time frame for reporting and investigating abuse and neglect. She said the day they told her about the incident she had intended to investigate and report it but did not get a chance. She said she had missed it. In an interview on 10/28/2025 at 3:50pm LVN B said she was the nurse working at the time the incident occurred. She said it was around dinnertime and Resident #2 was in bed, the bed was in the lowest position, and she heard her yelling and when she got to the room the resident was at the door on the floor on her left side and bleeding. She said Resident #2 had a skin tear with blood and hematoma to the forehead. She said she immediately checked her vitals, called the MD, DON, 911, cleaned the area to the forehead and Resident #2 was sent out 911 to the nearest hospital. She said Resident #2 returned from the hospital the same day with no stitches, bleeding, or fracture. In an interview on 10/28/2025 at 5:14pm, the Administrator said usually when there was an incident regarding abuse, neglect or exploitation they would report to the administrator. She said if it were nursing issues then the staff would report to the DON or Charge nurse, and they would inform her. She said she was informed about Resident #2's fall and had got written up because it was not investigated and reported within the reporting time frame. She said she will ensure that all incidents regarding abuse, neglect and exploitation would be

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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 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. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that residents were free of medication errors for 1 (Resident #1) of 5 residents reviewed for medication errors. Resident #1's October 2025 MARs did not reflect documentation that Diclofenac three times a day was done as ordered. This failure could place residents at risk of not getting their medications as ordered, which could result in residents not receiving the therapeutic benefits of the medication including increased pain and decreased quality of life.Record review of Resident #1's admission face sheet, dated 10/24/2025, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anemia (a condition were the body does not enough red blood cells), heart failure (when the heart muscle does not pump blood as well as it should), hyperlipidemia(high levels of fat in the blood), hemiplegia/hemiparesis, depression(mental health condition characterized by feelings of sadness and loss of interest in activities), malnutrition (a condition where the body does not have adequate calories such as vitamin, protein and minerals), morbid obesity(sever form of obesity characterized by an high body mass index), chronic diastolic heart failure (a condition where the heart muscle is unable to relax properly) and osteoarthritis (common joint disease that causes pain and stiffness and swelling in the joints). Review of Resident #1's initial MDS, dated [DATE], revealed a BIMS score of 11, indicating Resident #1's cognitive skills for decision making were intact. for functional abilities he was coded: for eating, oral hygiene as set up assistance, for toileting and putting and taking off footwear, he was coded as dependent on staff for assistance, for shower/bathe self, upper/lower body dressing he was coded as needing substantial/maximal assist and for personal hygiene he was partial/moderate assist, for bowel and bladder, he was coded as always incontinent. Record review of Resident #1's physician's order, dated 08/31/2025 and discontinued on 10/13/2025, revealed: Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical), apply to 2g to left knee topically three times a day for pain apply 2g to affected area. Record review of Resident #1's Medication Administration Record for 10/2025 revealed:MAR dated 10/02/2025 in the PM revealed no documentation that the treatment was administered 5:00pm. There was a blank on the MARS for Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical), apply to 2g to left knee topically three times a day for pain apply to affected area. Record review of Resident #1's nurse's progress notes dated 10/02/2025, revealed no documentation as to why Diclofenac Sodium External Gel 1% (topical) for pain was not done. During an observation on 10/24/2025 at 11:55 a.m., Resident #1 was lying in bed resting. Resident #1 was alert and oriented and could make his needs known. He was clean, well-groomed with no offensive odor, and the call light was observed to be within reach. In an interview on 10/24/2025 at 11:55 a.m., Resident #1 said he was not abused or neglected by staff. He said sometimes, he did not get what he ordered to eat. He said he was getting routine pain medication for his knee but now he gets his pain medication when he complained of pain, and they always give it to him. In an interview on 10/28/2025 at 4:00 p.m., LVN C said she was not the one who provided treatment to Resident #1. She said there should be no blanks on the MARs/TARs. She said if there were blanks on the MARs/TARs it would be difficult to determine if the medication was given or not given. She said if the treatment or medication was not done there should be a check stating why it was not done but there should be no blanks on the MARs. In an interview on 10/28/2025 at 5:00 p.m., RN A said there should be no blanks on the MARs /TARs. She said whether the treatment was done, or not, it should be documented. She said she must pay more attention and always document when medications were given and or not given. She said blanks on the MARs could indicate the medication was given or not given. She said this should be a learning experience for the nurses to always document and ensure that no blanks were on the MARs. In an interview on 10/28/2025 at 5:30pm, the Administrator said the resident record should be complete and accurate. She said they were going to do a complete audit of resident's medical records. She said the nursing staff would would be in-serviced on documentation regarding physician's orders, medication administration and the adverse effect of not documenting could influence resident's care. She said her expectations of the staff were to ensure the physician's orders were followed and documented in the clinical records. She said the plan going forward was to ensure that staff were documenting accurately in resident clinical records. Record review of the facility policy titled, Medication Administration, dated 07/2025, revealed .21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose 22. The individual administering the medication initials the

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 2 of 5 Residents (Resident #1 and Resident #2) reviewed for medical records accuracy. Resident #1's October 2025 MARs did not reflect documentation that Diclofenac three times a day was done as ordered. Resident #2's October 2025 MARs did not document Accu-check as done on 10/2/2025. This deficient practice could place residents at risk for errors in their care and treatment. Record review of Resident #1's admission face sheet, dated 10/24/2025, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anemia (a condition were the body does not enough red blood cells), heart failure (when the heart muscle does not pump blood as well as it should), hyperlipidemia(high levels of fat in the blood), hemiplegia/hemiparesis, depression(mental health condition characterized by feelings of sadness and loss of interest in activities), malnutrition (a condition where the body does not have adequate calories such as vitamin, protein and minerals), morbid obesity(sever form of obesity characterized by an high body mass index), chronic diastolic heart failure (a condition where the heart muscle is unable to relax properly) and osteoarthritis (common joint disease that causes pain and stiffness and swelling in the joints). Review of Resident #1's initial MDS, dated [DATE], revealed a BIMS score of 11, indicating Resident #1's cognitive skills for decision making were intact. For functional abilities he was coded: for eating, oral hygiene as set up assistance, for toileting and putting and taking off footwear, he was coded as dependent on staff for assistance, for shower/bathe self, upper/lower body dressing he was coded as needing substantial/maximal assist and for personal hygiene he was partial/moderate assist, for bowel and bladder, he was coded as always incontinent. Record review of Resident #1's physician's order, dated 08/31/2025 and discontinued on 10/13/2025, revealed: Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical), apply to 2g to left knee topically three times a day for pain apply 2g to affected area. Record review of Resident #1's MAR dated 10/2025 revealed:Record review of the MAR dated 10/02/2025 revealed no documentation that Diclofenac Sodium External Gel 1% was administered 5:00pm. There was a blank on the MARS for Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical), apply to 2g to left knee topically three times a day for pain. Record review of Resident #1's nurse's progress notes, dated 10/02/2025 written by, revealed no documentation as to why the treatment was not done Record review of Resident #2's admission face sheet, dated 10/24/2025, revealed Resident #2 was an [AGE] year-old female admitted on [DATE]. Resident #2's diagnoses included hypertension (high blood pressure), diabetes (high blood sugar), hyperlipidemia (high level of fat in the blood), malnutrition (when the body does not get enough calories, vitamin , minerals and protein), schizophrenia (a chronic mental health condition that impacts a person's thoughts, feeling and behaviors), anxiety disorder (mental health condition characterized by worry, fear and nervousness), depression (mental health condition characterized by feelings of sadness and loss of interest in activities), muscle weakness (loss of muscle strength), and dysphagia (difficulty swallowing). Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 02, indicating Resident #2 was cognitively impaired, indicating skills for decision making were not intact. For Functional abilities, she was coded: for eating - supervision assistance, for toileting - putting on and taking off footwear, shower/bathe self, upper/lower body dressing, and for personal hygiene she was coded as partial/moderate assist, and for bowel and bladder, she was coded as always incontinent. Record review of Resident #2's physician's order summary report revealed an order for Accu-Chek twicedaily, in: AM and PM (Report result over >300 to NP/MD). two times a day related to DM Type 2. Record review of Resident #2's TAR for October 2025 revealed the Accu-Chek was not documented as checked on 10/02/2025 at 5:00pm. Further record review of the TAR revealed there were blanks on the treatment administration records. Record review of Resident #2's nurse's progress notes, dated 10/02/2025, revealed no documentation as to why the Accu Check was not done. Observation on 10/24/2025 at 11:45 am revealed Resident #2 was lying in bed resting. Resident #2 was alert and oriented with confusion. She was clean, well-groomed with no offensive odor, and the call light was observed to be within reached. interview on 10/28/2025 at 4:00 p.m., LVN C said she was not the one who provided treatment to Resident #1. She said there should be no blanks on the MARs/TARs. She said if there were blanks on the MARs/TARs it would be difficult to determine if the medication was given or not given. She said if the treatment or medication was not done there should be a check stating why it was not