

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 02/05/2026
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's discharge summary included an accurate reconciliation of all pre-discharge medications with post-discharge medication for 1 of 1 Residents reviewed for discharge medication reconciliation. The facility failed to complete an accurate reconciliation of medications for Resident #1 when he was discharged home on 1/31/2026. This failure could place residents at risk for discontinuity of care after being discharged from the facility to their home. Findings include: Record review of Resident #1's face sheet dated 2/2/2026 showed a [AGE] year old male was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (a medical condition where a patient experiences complete paralysis or weakness on the left side of the body because of a cerebral infarction, commonly known as a stroke, affecting the non-dominant hemisphere of the brain), bipolar disorder (a condition characterized by extreme mood swings including periods of mania and depression), type 2 diabetes mellitus (a chronic disease that is characterized by high levels of sugar in the blood), and cognitive communication deficit (a condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes, rather than a primary problem with language or speech). Record review of progress notes showed that Resident#1 was discharged from the facility to his responsible party's home on 1/31/2026. There was a physician order to discharge Resident#1 received by the facility on 1/30/2026 that read, may discharge home with sister POA with scheduled medications no narcotics and all other belongings. Record review of a document titled Medications Released on Leave of Absence that was saved in Resident #1's electronic record as discharge medication list and signed on 1/31/2026 by the DON and resident's responsible party did not list insulin as a medication sent home with Resident #1. Record review of Resident #1's active orders at the date and time of discharge on [DATE] indicated the following orders for insulin: 1. Humalog injection solution (Insulin Lispro). Inject 5 IU subcutaneously two times a day for DM. Hold for BS less than 100. Order date 1/23/2026. Discontinue date 2/2/2026. 2. Insulin Glargine Solution 100 unit/ml. Inject 30 units subcutaneously two times a day for diabetes. Hold for BS less than 80. Order date 1/23/2026. Discontinue date 2/2/2026. Record review of Resident #1's care plan with an initiation date of 10/27/2025, listed DM as a focus with interventions that included to monitor and document for side effects and effectiveness of diabetic medication as ordered and listed Insulin Glargine as a medication that Resident #1 is receiving. Interview with the DON on 2/4/2026 at 10:40 am revealed she had been working as the DON since April 2024 and worked the shift when Resident #1 was discharged from the facility. The DON stated that she gathered Resident #1's scheduled medications except his narcotics and gave them to Resident #1's responsible party and they both signed a discharge medication list. She stated she didn't think Resident #1 had insulin prescribed, and if he did, she would have sent home the insulin as well. Interview with LVN A on 2/4/2026 at 1:47 pm</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675052
		If continuation sheet Page 1 of 2

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>revealed she was working on the day Resident #1 was discharged and was his nurse. She stated that the DON said she was going to take care of Resident #1's discharge medications which included gathering them and getting the responsible party to sign the discharge medication form. LVN A stated that insulin should be sent home with a resident who is being discharged home along with any other scheduled medications except narcotics. Interview with the DON on 2/4/2026 at 2:06 pm revealed that Resident #1 did have active orders for insulin at the time of discharge. The DON stated that insulin should have gone home with Resident #1. When asked why it didn't, the DON stated she was helping the nurse on duty and listed the medication that was handed to her. The DON stated that she overlooked it. The DON stated neither Resident #1 nor his responsible party mentioned anything about the insulin. The DON stated that she assumed what she was handed by LVN A was all the medications that were ordered for Resident #1. The DON stated that Resident #1's insulin was in a separate area in the nurse's medication cart, and the medications that were handed to her were in the Medication aide's cart. The DON also stated that she was the nurse who signed off on the discharge summary which stated on page 2-part B under drug therapy to see MAR. The DON was able to point out insulin on the MAR that Resident #1 had two insulin orders. The DON stated that the risk of not sending home insulin with the resident included hyperglycemia that could lead to hospitalization or even death. Interview with Regional Senior Administrator on 2/4/2026 at 3:00 pm revealed from her understanding, narcotics are the only medications not sent home with residents when discharged. She stated insulin usually goes home with residents. She stated she was in the facility because the current Administrator had only been in her role for two days and was new to the facility and new to the role of an administrator. The former Administrator who was employed during the time Resident #1 was discharged was no longer employed at the facility. When asked what kind of training nurses receive for discharging a resident, she stated that it is covered during a nurse's orientation on the floor. She stated that there was no written policy for specific actions for nurses to take in regard to discharging a resident. Record review of the facility guide that was not dated and read Planned Discharge Documentation read in part .send medication with exception of discontinued medications and/or narcotics, with Resident and/or RP. Provide education on medications and administration to Resident and/or RP and have Resident and RP sign verification of any medications received upon discharge as applicable .</p>		