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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Ridge Healthcare Center	208 South Utah LA Porte, TX 77571

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (CR #1) of 5 resident reviewed for notification of changes. RN A failed to notify CR #1's physician immediately when at approximately 6:30 am on [DATE], CR # 1 was delusional and looked pale yellowish. RN A failed to consult with CR #1's physician immediately for medical guidance when at approximately 8:00 am on [DATE], CR #1's oxygen saturation level was 84%. RN A waited until 12:30 pm to notify CR #1's physician regarding CR #1's change in condition after CR #1 became minimally responsive. On [DATE] at approximately 1:00 pm, CR #1 was sent to the hospital due to low oxygen saturation level. CR #1 was admitted to ICU with respiratory distress and hypotension. During ICU evaluation CR #1 experienced pulselessness prompting resuscitative efforts. After about 20 minutes of resuscitative efforts, CPR was terminated per daughter's request, and CR #1 was pronounced deceased at 8:53 pm on [DATE]. On [DATE] at 5:49 pm, an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the residents' condition, and /or sepsis, stroke, or death. Record review of CR #1's face sheet, dated [DATE], revealed a [AGE] year-old female readmitted to the facility on [DATE] after an extended stay in an LTAC. CR #1's admitting diagnoses on [DATE] included: acute gastric ulcer with perforation (an open sore in the stomach lining that eats completely through the stomach wall creating a hole), UTI (an infection caused by bacteria entering the urinary system), acute respiratory failure with hypoxia (when lungs suddenly stop working properly, leaving blood dangerously low on oxygen), sepsis (body's extreme life-threatening response to an infection) and atelectasis (partial or complete collapse of the lung). Record review of CR #1's quarterly MDS assessment, dated [DATE], revealed a BIMS of 15 indicating intact cognition and memory. Record review of CR #1's Care Plan dated [DATE], indicated CR #1 had Emphysema/COPD with interventions to monitor for difficulty breathing on exertion and to monitor for s/s of acute respiratory insufficiency: anxiety, confusion, restlessness. Record review of CR #1's active physician's order summary for [DATE] indicated an order for Bipap (a machine that pumps pressurized air through a mask to keep airways open, giving higher pressure when breathing in and lower pressure when breathing out) with settings: (16/8, 40% FiO2 (fraction of inspired oxygen) nightly and 3Liters O2 via nasal canula related to Chronic Obstructive Pulmonary disease and Acute Respiratory failure with Hypoxia. An order for Ipratropium-albuterol inhalation solution (a prescription liquid medication that is vaporized into a mist and breathed in to open up the airways) 0.5-2.5 (3) mg/3ml inhale orally to be given every 6 hours as needed for shortness of breath. Further record review on CR #1's physician order revealed there was no monitoring in place for CR #1's O2 saturation level. During an interview on [DATE] at 1:09 pm, MA B said she made it to CR #1's (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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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	room around 7:15 am on [DATE] to administer morning medications. MA B stated she got all her medications ready, but when she approached CR #1, she observed CR #1 was out of it. MA B said CR#1 was mumbling, seemed confused, and was saying things that could not be understood. MA B stated that she could not understand CR #1 and notified RN A to come assess her immediately. MA B stated she informed RN A that she was not comfortable administering medications to CR #1 and RN A instructed MA B to hold CR #1's morning medication. MA B stated she did not know what interventions were provided to CR #1 after she reported to RN A at 7:30 am and continued with her medication pass. MA B stated when she asked RN A if CR #1 was going to be sent to the hospital, RN A said that she was not sure. MA B stated she continued to pass medications on other halls and was not aware of any updates about CR #1 until she saw EMS leave with CR #1 around lunch time. MA B stated when she asked RN A, RN A told her CR #1's oxygen saturation level was not increasing. Record review of Resident #1's progress notes, dated [DATE] at 11:27 am, revealed that CR #1's oral medication was held due to lethargy, confusion, and she was considered a high aspiration risk. During an interview on [DATE] at 1:35 pm, RN A stated on the morning of [DATE], after getting shift report from the night nurse, she made her rounds to CR #1's room around 6:30 am. RN A stated she noticed CR #1 was mumbling to herself like she was delusional which was unusual for CR #1. RN A stated CR #1 had her nasal canula on at 4 LPM and looked pale and yellowish. RN A stated she continued to finish her rounds. RN A stated MA B notified her that she was not comfortable to administer medications to CR #1 and asked RN A to assess CR #1. During RN A's assessment, she noticed CR #1 taking deep breaths through her mouth although she wore her nasal canula and she notified the DON. RN A said the DON and RN A obtained CR#1's O2 saturation at 84%. RN A stated that the DON said the O2 saturation of 84% was CR #1's baseline and suggested to put the Bipap on since resident had her nasal canula on and was breathing through her mouth RN A stated on [DATE] around 11am, she reassessed CR #1 after putting the Bipap on. RN A stated she could not get an oxygen saturation level (the percentage of red blood cells carrying oxygen compared to the total amount of oxygen in blood). RN A stated she tried 2 different pulse oximeters and was still unable to get an O2 level reading. RN A stated she tried the pulse oximeter on her own hands and was able to get a reading immediately. RN A stated one minute CR #1 was talking, mumbling and confused and then CR #1 had stopped talking and color had changed. RN A stated she notified MD at 12:30 pm who gave orders to send CR #1 out to the hospital. RN A stated she called 911 who arrived immediately. RN A stated EMS took CR #1's O2 level, and it was 82%. RN A stated CR #1 was moaning and mumbling when EMS was wheeling her out of the facility at 1:00 pm. RN A stated the interventions she implemented were changing the oxygen to Bipap and making sure the Bipap was on properly. RN A stated she did not feel CR #1 was sent out late and she did not notify MD sooner because she wanted to collect data and present a case to the MD. RN A stated when she realized she could not do anything to bring CR #1's O2 saturation up, she asked for help from other staff on the procedure to send a resident out. She stated she felt that an 84% O2 saturation was a concern and that was why she got the DON. RN A stated she followed the DON's instructions to keep CR #1 in the facility and monitor her with the Bipap being on. During an interview on [DATE] at 2:35 pm, CNA C stated that while completing her round on [DATE] at 6:15 am, CR#1 did not have her Bipap on and she checked to make sure she was breathing. CNA C stated when she tried to feed CR #1 breakfast, CR#1 had her eyes closed and was talking to herself. CNA C stated CR#1 said that she did not want to eat and CNA C stopped because she did not feel it was safe in her current state. CNA C stated CR #1 told her that she did not want to eat breakfast and that she was tired. CNA C stated RN A was notified. CNA C stated she checked on CR #1 at least 3 times before she was transferred. CNA C stated each time she saw her, CR #1 denied being wet and had her eyes closed talking to herself. CNA C stated no Bipap was observed during each check-in. During an interview on [DATE] at 2:59 pm, the DON stated CR #1 was non-compliant with using the Bipap. The DON stated when she checked at 11:00 am, CR #1'soxygen was on at 4 LPM via nasal canula and O2 saturation level were at 93%. The DON stated for an obese woman, 4 LPM was ok and her order was (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for 02 sats to be kept over 90%. The DON stated she then left CR #1's room and RN A was in the room. DON stated at 12:30 pm, RN A informed her that CR #1 had a change in condition and had order from the MD to send her out. DON stated the change in condition was that CR #1 was not as responsive and the O2 saturation had dropped. DON stated after RN A informed her of CR #1's condition that morning, she instructed RN A to put CR #1's Bipap mask on if CR #1 allowed it, but she did not return to monitor CR #1 because other staff were doing so. The DON stated when she left the room RN A was putting the Bipap mask on for CR #1. DON stated that if CR #1's O2 saturation levels were below 90% or 83%, she would have notified the MD and would have gotten an order to send CR #1 out. The DON stated she was not aware that CR #1's O2 sats were below 90% for a long period of time. DON stated that if the O2 sats were low, it was better to send CR #1 out sooner than later for further evaluation. DON stated CR #1 was already on 4LPM NC and on Bipap but had a bad lung disease that had declined. DON stated her expectation was for nurses to notify the MD, herself, and Administrator immediately if there was a change in condition. DON stated the only thing that could have been done for intervention was to send CR #1 sooner to the hospital. Record review of CR #1's progress notes for Change in Condition note on [DATE] at 12:30 pm documented CR #1 had an O2 saturation of 80% on a nasal canula, breathed through her mouth, and appeared pale with yellow-gray coloration. CR #1 was minimally responsive with no response to verbal stimuli. She had an altered mental status with delusions, indicated by her speaking to her mother who was not present in the room. CR #1 refused breakfast and lunch. CR#1's responsiveness and oxygenation continued to decline during shift. CR #1 was ordered to be sent to the hospital by MD and left via EMS at 1:00 pm. During an interview on [DATE] at 12:37 pm, the MD stated he was notified by RN A that CR # 1 was not as responsive as usual and that her 02 level was low. The MD stated he instructed RN A to send CR #1 to the hospital. The MD stated he did not remember receiving any other vital signs other than CR #1's 02 level. The MD stated he was not aware that CR #1 had other changes in condition going on at the same time. The MD stated the facility should notify him immediately if there was a significant change. The MD stated in CR # 1's case the risk of not receiving appropriate assessment sooner was catastrophic. The MD stated CR #1 had the worst outcome, death. The MD stated the risk of receiving delayed emergency care would result in worsening symptoms and harder to treat conditions. Record review of the facility's policy titled, Condition & MD-Family Notification, revised [DATE] and reviewed [DATE], read in part, .PROCEDURE: The physician will be contacted immediately for any emergencies irrespective of the time of day.Each attempt will be charted as to the time the call was made, who was spoken to and what information was given to the physician. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 5:49 pm. The Administrator and DON were notified. The Administrator and DON were provided with the IJ templated [DATE] at 5:49pm. The following Plan of Removal submitted by the facility was accepted on [DATE] at 3:11pm. It was documented as follows:F580 Notify of ChangesThe facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).Situation: CR#1 passed away at the hospital. Charge Nurse removed from the schedule by DON on [DATE].The Director of Nursing (or designee) reviewed all current residents who had experienced a significant change in condition and those currently exhibiting a significant change in condition to verify that physician notification had occurred timely, physician orders had been received and implemented as appropriate, and no residents remained at risk due to delayed physician notification. Any identified concerns were immediately addressed. No residents identified having concerns with change of condition.Completed [DATE].All licensed nurses received immediate education regarding the facility's expectations for timely physician notification whenever a resident experiences a significant change in condition. Education included recognizing changes that require immediate physician notification, communicating pertinent clinical information to the physician, documenting the notification, physician response, and implementation of any resulting orders. Staff (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will not be allowed to provide direct resident care until training was completed.The Director of Nursing reinforced the expectation that physician notification will occur immediately upon identification of a significant change in condition and will not be delayed while additional information is gathered if the resident's condition warrants prompt medical evaluation.QAPI committee reviewed its policies and procedures related to change in condition and physician notification to ensure compliance. No updates made to policy reviewed [DATE].Completed [DATE]. Director of Nursing/Regional Nurse provided immediate re-education to all licensed nurses on the following: The expected process for: 1. Immediately evaluating/assessing resident upon a suspected or identified change in condition noted. 2. Documenting nursing findings to include but not limited to evaluation of vital signs and utilizing the appropriate Change in Condition User Defined Assessment and/or Nursing Progress Note to ensure proper documentation is noted within the medical record. 3. Nurse to promptly report the identified change in condition (exception of usual baseline status) to the Medical Provider in order to ensure appropriate interventions are provided and carried out as ordered/recommended. 4. Nurse to ensure that appropriate notification is made to the resident's representative. 5. The Nurse should review the vital sign form to ensure that any abnormal vital signs have been reviewed by the nurse with appropriate re-assessment and interventions to include the licensed nurse conducting the evaluation/assessment, notification to the Medical Provider, carrying out any recommended or prescribed medical interventions and notification to the resident's representative promptly, and ensuring all is documented within the electronic health record. 6. The nurse will ensure that all identified changes in condition or suspected changes in condition will be reported to the on-coming nurse to ensure appropriate 24-hour reporting at change of shift as per usual hand-off process.Director of Nursing Services/Regional Nurse completed a 100% audit on all residents in the community to identify any residents with a change in condition. Outcome: 0 of 33 active residents were noted with no identified change in condition.Completed [DATE] Monitoring/Verification of Plan of removal: [DATE] Record review reflected that facility-wide in-services and a quiz conducted between [DATE], [DATE] and [DATE] were completed across all shifts under the direction of clinical leadership. Thirteen Licensed Nurses were educated to notify physicians of changes in conditions promptly to ensure timely assessment, treatment, and resident safety. Upon completion of this in-service, licensed nurses will be able to: recognize what constitutes a significant change in condition, notify the physician promptly when a significant change occurs, provide accurate clinical information during physician notification, implement physician orders immediately, document the notification, physician response, and interventions accurately. Review of in-service reflected Licensed nurses were in-serviced on identifying a significant change in condition which was defined as a decline or improvement in a resident's physical, mental, or psychosocial status that requires physician evaluation or intervention. Examples of significant change in condition included: change in level of consciousness, respiratory distress or oxygen desaturation, chest pain, acute change in blood pressure, pulse, respirations, or temperature, new onset confusion or altered mental status, falls with injury or suspected injury, uncontrolled pain, new bleeding, significant change in blood glucose and any condition requiring possible transfer to a higher level of care. Review of the in-service reflected when a change in condition was identified licensed nurses were expected to:- Assess the resident immediately, Obtain pertinent vital signs and clinical information, Notify the physician without delay, Do not wait to gather additional information if the resident's condition warrants immediate medical evaluation, Receive and accurately read back physician orders, Implement orders promptly, Continue monitoring the resident and document the response, Notify the resident representative as appropriate per facility policy. Review of the in-service reflected licensed nurses are to document the following: - Time the change in condition was identified, Assessment findings, Time physician was notified, Physician name, information communicated, Orders received, Time orders were implemented, Resident response, Notification of resident representative when applicable. Review of the facility's Change in Condition audit tool reflected daily audits were (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conducted.On [DATE], all 33 residents were reviewed with compliance noted for all residents.On [DATE], 34 residents were reviewed with 1 resident identified with a change in condition that occurred at the time the audit was being conducted. The resident was on end-of-life care (hospice care). Nurses conducted appropriate assessments, communication with the Medical Provider, orders received, change in condition was documented within the electronic health record and appropriate notifications to RP were made and the nursing 24-hour communication report was updated accordingly. The resident returned from hospital to facility on the same day ([DATE]).On [DATE], all 34 residents were reviewed with compliance noted for all residents.Review of the facility's vital signs monitoring audit tool reflected all residents' vital signs were completed daily from [DATE] to [DATE] with no abnormalities. Staff interviews:During interview conducted on [DATE] between 4:00pm to 4:30pm, LVN D and RN B, who worked the 6:00 am to 6:00 pm shift, stated they were agency nurses. They said they were in-serviced the morning of [DATE] prior to start of shift on identifying changes in condition with residents and promptly notifying physicians. LVN D and RN B stated that changes in condition were identified as deviations from baseline (altered mental status, abnormal vital signs) and required completion of CIC assessments, documentation in progress notes, and family and physician notification. LVN D and RN B stated they completed 2 quizzes as part of the in-services. On [DATE] at 6:45pm, an attempt was made to interview nurses from the evening shift from 6:00pm to 6:00am but nurse had not arrived and another nurse was not available. The Administrator and DON were informed the Immediate Jeopardy was removed on [DATE] at 7:22 p.m. The facility remained out of compliance at a severity level of minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (CR#1) of 5 resident reviewed for quality care. The facility failed to ensure CR #1 received treatment and care promptly when CR #1 experienced a change in condition of altered mental status and respiratory decline with low Oxygen saturation level. The facility failed to obtain an order for interventions including order to send CR#1 to hospital for further evaluation and treatment when CR #1's altered mental status was first identified around 6:30am on [DATE] and a decline in respiratory status with low oxygen saturation level identified around morning med pass on [DATE]. The facility failed to properly assess CR#1 or obtain vital signs after a change in condition of altered mental status and respiratory decline was identified. CR # 1 was not administered breathing treatment for shortness of breath as per physician order. The facility waited approximately 4-5 hours to notify CR #1's physician after observing the change in condition. On [DATE] at 5:48pm, an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated and due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the residents' condition and /or sepsis, stroke, or death. Findings included: - Record review of CR #1's face sheet dated [DATE] revealed a [AGE] year-old female readmitted to the facility on [DATE] after an extended stay in an LTAC. CR #1's admitting diagnoses on [DATE] included:- acute gastric ulcer with perforation (an open sore in the stomach lining that eats completely through the stomach wall creating a hole), UTI (an infection caused by bacteria entering the urinary system), acute respiratory failure with hypoxia (when lungs suddenly stop working properly, leaving blood dangerously low on oxygen), sepsis (body's extreme life-threatening response to an infection) and atelectasis (partial or complete collapse of the lung). Record review of CR #1's quarterly MDS dated [DATE] revealed a BIMS of 15 indicating intact cognition and memory. Record review of CR #1's Care Plan indicated CR #1 had Emphysema / COPD with interventions to monitor for difficulty breathing on exertion and to monitor for s/s of acute respiratory insufficiency: anxiety, confusion, restlessness. Record review of CR #1's active physician's order summary for [DATE] indicated an order for Bipap with settings: (16/8, 40% Fio2(fraction of inspired oxygen) nightly and 3Liters O2 via nasal canula related to Chronic Obstructive Pulmonary disease and Acute Respiratory failure with Hypoxia. An order for Ipratropium-albuterol inhalation solution (a prescription liquid medication that is vaporized into a mist and breathed in to open up the airways) 0.5-2.5 (3) mg/3ml inhale orally to be given every 6 hours as needed for shortness of breath. Further record review on CR #1 physician order revealed there was no monitoring in place for CR #1's O2 saturation level. Record review of CR #1's vital signs documentation record revealed no vital signs were obtained for CR #1 on [DATE]. Record review of CR #1's SBAR 3.0 assessment with effective date [DATE] at 1:00 pm indicated the most recent blood pressure reading was 128/76 obtained on [DATE] at 8:24pm; the most recent pulse was 86 obtained on [DATE] at 8:24pm; the most recent respiration was 16 obtained on [DATE] at 8:53am; the most recent temperature was 98.1 degrees obtained on [DATE] at 7:50pm and the most recent O2 sats were 93% via nasal canula obtained on [DATE] at 7:40am. Further review revealed CR #1 was on oxygen at 4 liters and the most recent blood glucose was 158 mg/dl obtained on [DATE] at 7:39 am. During an interview on [DATE] at 1:35 pm, RN A stated on the morning of [DATE], after getting shift report from the night nurse, she made her rounds to CR #1's room around 6:30 am. RN A stated she noticed CR #1 was mumbling to herself like she was delusional which was unusual for CR #1. RN A stated CR #1 had her nasal canula on at 4 LPM and looked pale and yellowish. RN A stated she continued to finish her rounds. RN A stated MA B notified her that she (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was not comfortable to administer medications to CR #1 and asked RN A to assess CR #1. During RN A's assessment, she noticed CR #1 taking deep breaths through her mouth although she wore her nasal canula and she notified the DON. RN A said the DON and RN A obtained CR#1's O2 saturation at 84%. RN A stated that the DON said the O2 saturation of 84% was CR #1's baseline and suggested to put the Bipap on since resident had her nasal canula on and was breathing through her mouth RN A stated on [DATE] around 11am, she reassessed CR #1 after putting the Bipap on. RN A stated she could not get an oxygen saturation level (the percentage of red blood cells carrying oxygen compared to the total amount of oxygen in blood). RN A stated she tried 2 different pulse oximeters and was still unable to get an O2 level reading. RN A stated she tried the pulse oximeter on her own hands and was able to get a reading immediately. RN A stated one minute CR #1 was talking, mumbling and confused and then CR #1 had stopped talking and color had changed. RN A stated she notified MD at 12:30 pm who gave orders to send CR #1 out to the hospital. RN A stated she called 911 who arrived immediately. RN A stated EMS took CR #1's O2 level, and it was 82%. RN A stated CR #1 was moaning and mumbling when EMS was wheeling her out of the facility at 1:00 pm. RN A stated the interventions she implemented were changing the oxygen to Bipap and making sure the Bipap was on properly. RN A stated she did not feel CR #1 was sent out late and she did not notify MD sooner because she wanted to collect data and present a case to the MD. RN A stated when she realized she could not do anything to bring CR #1's O2 saturation up, she asked for help from other staff on the procedure to send a resident out. She stated she felt that an 84% O2 saturation was a concern and that was why she got the DON. RN A stated she followed the DON's instructions to keep CR #1 in the facility and monitor her with the Bipap being on. Record review of CR #1's MAR for [DATE] revealed CR#1 was not administered Ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml inhale orally every 6 hours as needed for shortness of breath as per physician's order when Cr #1 was having respiratory issues on [DATE]. During an interview on [DATE] at 2:59 pm, the DON stated CR #1 was non-compliant with using the Bipap. The DON stated when she checked at 11:00 am, CR #1'soxygen was on at 4 LPM via nasal canula and O2 saturation level were at 93%. The DON stated for an obese woman, 4 LPM was ok and her order was for 02 sats to be kept over 90%. The DON stated she then left CR #1's room and RN A was in the room. DON stated at 12:30 pm, RN A informed her that CR #1 had a change in condition and had order from the MD to send her out. DON stated the change in condition was that CR #1 was not as responsive and the O2 saturation had dropped. DON stated after RN A informed her of CR #1's condition that morning, she instructed RN A to put CR #1's Bipap mask on if CR #1 allowed it, but she did not return to monitor CR #1 because other staff were doing so. The DON stated when she left the room RN A was putting the Bipap mask on for CR #1. DON stated that if CR #1's O2 saturation levels were below 90% or 83%, she would have notified the MD and would have gotten an order to send CR #1 out. The DON stated she was not aware that CR #1's O2 sats were below 90% for a long period of time. DON stated that if the O2 sats were low, it was better to send CR #1 out sooner than later for further evaluation. DON stated CR #1 was already on 4LPM NC and on Bipap but had a bad lung disease that had declined. DON stated her expectation was for nurses to notify the MD, herself, and Administrator immediately if there was a change in condition. DON stated the only thing that could have been done for intervention was to send CR #1 sooner to the hospital. Record review of CR #1's progress notes for Change in Condition note on [DATE] at 12:30 pm documented CR #1 had an O2 saturation of 80% on a nasal canula, breathed through her mouth, and appeared pale with yellow-gray coloration. CR #1 was minimally responsive with no response to verbal stimuli. She had an altered mental status with delusions, indicated by her speaking to her mother who was not present in the room. CR #1 refused breakfast and lunch. CR#1's responsiveness and oxygenation continued to decline during shift. CR #1 was ordered to be sent to the hospital by MD and left via EMS at 1:00 pm. During an interview on [DATE] at 12:37 pm, the MD stated he was notified by RN A that CR # 1 was not as responsive as usual and that her 02 level was low. The MD stated he instructed RN A to send CR #1 to the hospital. The MD stated he did not remember receiving (continued on next page)

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	675052	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Ridge Healthcare Center	208 South Utah LA Porte, TX 77571

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	any other vital signs other than CR #1's 02 level. The MD stated he was not aware that CR #1 had other changes in condition going on at the same time. The MD stated the facility should notify him immediately if there was a significant change. The MD stated in CR # 1's case the risk of not receiving appropriate assessment sooner was catastrophic. The MD stated CR #1 had the worst outcome, death. The MD stated the risk of receiving delayed emergency care would result in worsening symptoms and harder to treat conditions. During an interview with the HRN on [DATE], she stated that CR #1 arrived at the hospital with shortness of breath, hypoxia and low blood pressure at 83/45. HRN stated EMS administered breathing treatment x1. HRN stated ER triage physical exam indicated CR#1 had a temperature 99.1; Pulse 107, Respiration 24, BP 87/28, O2 sat 91%. HRN stated CR#1 was intubated and within 20 minutes CR# lost pulse. CR#1 was treated with IV fluid and antibiotics and was transferred to ICU. HRN stated at approximately 8:00 pm CR#1 became pulseless and CPR was initiated. CR#1's RP requested to stop CPR after numerous attempts. CR# 1 was pronounced deceased at 8:53pm on [DATE]. Record review of facility's policy titled, Resident Examination and Assessment, read in part, . Purpose: The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan.Physical exam: #1. Vital Signs: blood pressure (standing and sitting); pulse (carotid); respirations; and temperature. #3. Respiratory: lung sounds (upper and lower lobes) for wheezing, rales, rhonchi, or crackles; irregular or labored respirations; cough (productive or nonproductive); and consistency and color of sputum.Reporting: #2. Notify the physician of any abnormalities such as, but not limited to abnormal vital signs; labored breathing; breath sounds that are not clear; or cough, productive or nonproductive; change in cognitive, behavioral or neurological status from baseline. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 5:48 p.m. The Administrator, DON, and ADON were notified. The Administrator and DON were provided with the IJ templated [DATE] at 5:48 p.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 3:11pm. It was documented as follows: F684 Quality of Care The facility failed to ensure CR #1 received treatment and care promptly in accordance with professional standards of practice who experienced a change in condition of altered mental status and respiratory decline with low Oxygen saturation level of 84%.Situation: CR#1 passed away at the hospital. Charge Nurse removed from the schedule by DON on [DATE]. The Director of Nursing (or designee) conducted a review of all current residents receiving oxygen therapy, BiPAP/CPAP, respiratory treatments, and/or those with significant respiratory diagnoses or documented changes in condition to ensure: A current nursing assessment had been completed; Vital signs and oxygen saturation had been obtained as clinically indicated; Physician notification had occurred when warranted; Physician orders had been implemented timely; and No resident was experiencing an unaddressed change in condition requiring immediate intervention. Any concerns identified during these reviews were addressed immediately. No Concerns were identified in audit completed [DATE].Completed date: [DATE] DON/Designee in serviced all licensed nurses on [DATE] and educated regarding the facility's expectations for: Prompt recognition and assessment of a significant change in condition; Completion of an appropriate nursing assessment, including obtaining pertinent vital signs and clinical information; Immediate physician notification when a significant change in condition is identified; Timely implementation of physician orders; and Accurate and timely documentation of assessments, physician notification, interventions, and resident response.The Director of Nursing also reinforced with licensed nursing staff the expectation that residents demonstrating a significant change in condition are assessed promptly and that physician notification occurs without unnecessary delay to ensure timely intervention. Staff will not be allowed to provide direct resident care until training has been completed.In addition to licensed nursing staff, all direct care staff were educated on [DATE], regarding recognition of changes in resident condition and the expectation to immediately report any observed change to the licensed nurse for prompt assessment and physician notification. Staff will not be allowed to provide direct resident care until training has been completed.Completed date: [DATE] QAPI committee reviewed its (continued on next page)

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