

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024
NAME OF PROVIDER OR SUPPLIER LA Bahia Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 225 E Ward St Goliad, TX 77963	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused result in serious bodily injury for 1 of 4 Residents (Resident #1) whose records were reviewed for abuse and neglect., in that; The facility failed to report to the state reporting agency (HHSC) an injury of unknown origin when Resident #1 suffered a change of condition and the hospital reported bleeding in the brain and a back fracture. This deficient practice could affect any resident and could contribute to further abuse and neglect. The findings were: Record review of Resident #1's face sheet, dated 5/10/2024 revealed an admitted [DATE] with diagnoses which included: type 2 diabetes mellitus with diabetic nephropathy (diabetes that causes damage to the kidneys), dementia, and end stage renal disease (severe kidney disease that results in the need for dialysis). Record review of Resident #1's Care Plan initiated on 8/03/2023 revealed her plan of care included dialysis three times a week and interventions for fall risk due to dependence on staff. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 which indicated a moderate cognitive impairment. The assessment also revealed the resident was non-ambulatory (could not walk), required substantiated assistance from staff for standing, transferring and repositioning, and was dependent on staff for ADL care. Record review of Resident #1's progress notes dated 5/08/2024 at 12:30 p.m. documented by LVN A revealed the facility (van) driver called and advised that dialysis staff were sending Resident #1 to a local ER due to nausea and vomiting. MD aware. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's hospital records dated 5/08/2024 revealed the resident presented to the ER with complaints of vomiting. Testing revealed a wedge compression fracture at L1 and L4 vertebra (fracture of one part of vertebrae causing collapse located on the lower part of the spine) which could be acute (less than 1 month old) or subacute (1 to 3 months old) and non-traumatic cerebrovascular accident/hemorrhagic infarct and cerebellar hemorrhage (stroke that happens when a blood vessel ruptures and bleeds and is not the result of an injury). During an interview on 5/09/2024 at 8:35 p.m., the Administrator stated Resident #1 went to dialysis yesterday (5/08/2024). He stated after being transported to dialysis she had issues with throwing up. The Administrator stated Resident #1 went to the hospital where it was discovered she had a brain bleed or aneurism and a lumbar fracture. He stated they (facility) did not know anything else. He stated they did not have any medical records from the hospital to confirm the diagnoses. The Administrator stated the facility had requested the medical records today (5/09/2024), but to his knowledge had not received them yet. The Administrator stated he found out about Resident #1's condition when dialysis called them and said she went to the hospital on 5/08/2024. He stated the DON called the hospital late on 5/08/2024 and that was how he knew of her injuries. The Administrator stated he did not report the injuries to HHSC (the state reporting agency) because they did not know anything definitive and because they do not have any incidents or accidents that would have caused these injuries. He stated they don't know what they have because this was an injury of unknown origin. The Administrator stated the facility process was to report injuries of unknown origin within two hours, but they have to get the documentation (from the hospital) to substantiate first. He stated we do not know where these injuries occurred, they could have happened at dialysis, but they had started their investigation. During an interview on 5/10/2024 at 11:00 a.m., with the DON, ADON, and the Regional Compliance Nurse, the DON stated Resident #1 was transported to the hospital from dialysis by ambulance. The DON stated she was not at the facility that day (5/08/2024). The DON stated when she called the ER, Resident #1 was still in the ER at the local hospital. She stated she was told by someone in the ER, who was not a clinical person, something about hemorrhaging and a fracture. The DON stated she told them she needed to speak with the nurse, and she needed clinical records. The DON stated the nurse did not call her back. The DON stated she followed up again with the hospital and found out Resident #1 had been transported to another hospital in a larger city and was stable. The DON stated the larger hospital verbally reported a fracture, but nothing was finalized and there was not final determination of fractures. She stated those were just preliminary findings. The DON stated they started their investigation on Wednesday (5/08/2024) when they were notified. During an observation and interview on 5/11/2024 at 11:05 a.m. at a local hospital, Resident #1 was in the ICU receiving dialysis. She was asleep and did not respond to verbal stimuli and was unable to answer questions. During an interview on 5/11/2024 at approximately 11:12 a.m., Resident #1's RP stated Resident #1 was not able to say what happened at the nursing home because she had confusion. The RP stated no incidents were reported to her. The RP stated the hospital told her Resident #1 had a stroke and a fracture. She stated the hospital told her the fractures had been there for a while. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/2024 at 10:21 a.m., the DON stated she did consider a fracture a serious injury. She stated she had reached out to the Administrator and the Corporate Compliance team about Resident #1's injuries. She stated she first learned of the fracture and brain bleed on 5/08/2024 from the receptionist and had requested a nurse to call her back which did not happen. She stated the next day on 5/09/2024 she requested the medical records. She stated serious injuries need to be reported (to HHSC) within two hours. She stated she reached out to her Administrator and corporate team about reporting, but it was the Administrator who made the self-reports. She stated she had access to TULIP, but not access to the self-reporting function . During an interview on 5/13/2024 at 2:45 p.m., the Administrator stated they had an abuse policy in place that required reporting (to HHSC) within a two-hour window. He stated but because of the way the incident occurred, he stated they needed some documentation (from the hospital) to confirm what the receptionist (non-clinical person) said. He said without confirmation, it held him back from reporting. The Administrator stated when someone who was not a medical professional says someone has fractures .well if it had been a family member who called and said she had fractures that might have been different. He stated, it did not mean anything unless they had to documentation to provide it, until then it was a questionable situation, a gray area which was why he made the deci [NAME] not to report . Record review of a facility policy, titled Abuse/Neglect last revised 3/29/2018 revealed: Definition: Injury of Unknown Origin: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. D. Identification: The facility will identify and investigate events that may constitute abuse/neglect. E. Reporting: 3. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. A. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation.		