

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 10/25/2024
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interview and record review, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-for 1 of 11 residents (Resident #2) reviewed for care plans, in that: The facility failed to ensure Resident #2's care plan was revised with updated interventions to address 4 of 6 actual falls (01/10/2024, 01/20/2024, 01/29/2024 and 02/08/2024) documented on incident reports and nursing notes. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings included: 1. Record review of Resident #2's face sheet dated 10/22/2024 reflected Resident #2 was admitted on 10 /31/2023 with re-admission on 09/07/2024 and was [AGE] years old. Resident #2 had diagnoses which included: Heart failure (condition where heart muscle can't pump blood as well as it should), fracture of left femur (10/21/2023) (breakage of left thigh bone); Obstructive and reflux uropathy (condition where urine cannot flow correctly through ureter, bladder or urethra), Diabetes Mellitus Type 2 (condition where body cannot regulate blood sugar); and Hemiplegia and hemiparesis (weakness and/or paralysis ono one side of body) following cerebral infarction (stroke) affecting left non-dominant side. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 99 indicating interview was unable to be completed. The MDS further assessed Resident #2 as being dependent for toileting hygiene, and requiring Maximal assist for shower/bathing, toilet transfers and sit to stand. Further review revealed Resident #2 was assessed as needing partial/moderate assist for chair/bed-to chair transfers and needing wheelchair for mobility. (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

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 10/25/2024
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Facility Incident Reports and Nursing notes from 11/01/2023 through 10/24/2024 revealed Resident #2 had unwitnessed falls with no injury on the following dates: 11/01/2023; 1/10/2024; 1/20/2024; 1/29/2024, 2/8/2024, and 02/23/2024. Record review of Resident #2's most recent comprehensive care plan reflected: Resident #2 had risk for falls- date initiated: 11/01/2023. Revision on: 12/06/2023. Interventions for this focus area of risk for falls were initiated on the following dates: - 11/01/2023 and included: Anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; ensure that the resident is wearing appropriate footwear when ambulating or mobilizing the w/c ; keep furniture in locked position; keep needed items, water, etc. in reach; may have floor mat to left side of bed; may have low bed ; PT evaluate and treat as ordered or PRN; review information on past falls and attempt to determine cause of falls. Record possible root cause. Alter remove any potential causes if possible. - 12/06//2023 - intervention to ensure appropriate footwear being worn revised - 02/19/2024 - Added focus area for using a bolster or concave mattress to prevent unintentional slipping/rolling out of bed. - 02/25/2024 -mechanical lift with staff x2 to assist with transfers. - 02/28/2024 -have bed positioned against wall per RP request. - 07/28/2024 - may have pressure call bell and may have low bed (revision) Further review of Resident #2's Care plan revealed that her Care Plan was not revised with updated interventions to address 4 of 6 actual falls (01/10/2024, 01/20/2024, 01/29/2024 and 02/08/2024) which occurred between 11/01/2023 and 02/23/2024 and were documented on incident reports and nursing notes. Interview on 10/23/2024 at 09:39 a.m. with the DON and MDS CM revealed that they are both responsible for updating Care Plans. The MDS CM stated she is responsible for annual and quarterly updates per OBRA care standards, noting when she revises the MDS, she updates the Care Plans at the same time and that the DON is responsible for updating Care Plans for any acute changes. The DON stated that the team does meet after resident falls to discuss possible causes and interventions such as in-servicing, but also stated any interventions implemented after Resident #2's falls (on 01/10/2024, 01/20/2024, 01/29/2024 and 02/08/2024) were not included in her Care Plan. The MDS CM confirmed there were no interventions documented on Resident #2's Care Plan following these falls. The MDS Case Manager stated they should have met after each fall and revised the Care Plan for Resident #2. (continued on next page)		

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 10/25/2024
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/2024 @ 10:43 a.m. with the RCN revealed that the DON is responsible for updating Care Plans for acute events such as resident falls. She stated that their policy following falls is for the team to meet, look at potential causes and implement interventions as soon as possible. She noted that there was no set time frame for the team to meet after each fall, but that the team should address falls as soon as possible, giving an example if a fall occurred on a Friday, the latest that team should meet is that following Monday. The RCN stated that the team should have met prior to 02/25/2024 to address the falls that occurred in January and early February 2024, and that not revising the Care Plan after each fall could result in not having interventions in place to prevent further falls. Record review of facility Comprehensive Care Planning Policy (undated) revealed The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or significant change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.		

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 10/25/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 16 residents (Resident #1) reviewed for accident hazards and supervision, in that: On [DATE] CNA A inappropriately transferred Resident #1 with a mechanical lift by herself, which caused a fall resulting in back pain from the mechanical lift support bar hitting her head and landing on the floor. The non-compliance was identified as PNC which began on [DATE] and ended on [DATE]. The facility had corrected the non-compliance before the survey began. This failure could result in residents requiring transfer by a mechanical lift suffering injury, a diminished quality of life, and/or death. The findings were: Record review of Resident #1's face sheet, dated [DATE], reflected a female age 88 readmitted to facility on [DATE] and discharged [DATE] due to death (heart failure) in the facility with diagnoses that included: dementia, CKD 2 (stage 2 chronic kidney disease), heart failure, fracture of third thoracic vertebra (12 bones in the middle section of the spine), unsteadiness of feet, specified disorders of muscle, abnormalities of gait and mobility, lack of coordination and lower back pain. RP was listed as: family member. Record review of Resident #1's discharge summary, dated [DATE], reflected resident noted with decline, placed on Hospice services. Hospice was called to pronounce. Expired in the facility. Discharge summary was signed by physician on [DATE]. Record review of Resident#1's MDS significant change assessment, dated [DATE], reflected the resident's BIMS Score was 1 indicating severe cognitive impairment. ADLs reflected that resident required max assist with transfers. Record review of Resident #1's Care Plan, revision date [DATE], reflected that the goals and interventions included: the resident has had falls r/t dementia, required assistance from staff for transfers. Resident had an actual fall [DATE]. Goal: free of falls, free of minor/serious injuries. Interventions included: may use [mechanical] lift for all transfers . staff x 2 to assist with transfers. Record review of Resident#1's MAR/Orders for ,d+[DATE], dated [DATE], reflected: DNR, floor mat to right side of bed, may use [mechanical] lift for all transfers every shift. Record review of Resident #1's Fall Risk assessment dated [DATE] reflected a score of 12 indicating a high risk for falls. (continued on next page)		

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 10/25/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of incident report dated [DATE] reflected that Resident #1 had a witnessed fall from walker to floor witnessed by CNA A. Resident was assessed and sent to ER for evaluation, negative results from X-ray and CT scan of head and spine. Intervention put in place ordered by physician was for resident to be transferred by 2 staff members. Facility in-service the nursing staff on fall prevention and transfer safety for the mechanical lift. CNA A attended the training. Record review of Resident #1's Event Nurses-Note and SBAR authored by LVN B dated [DATE] reflected that: Resident#1 got her foot stuck in the front leg of walker and fell witnessed by CNA A. Resident was evaluated and sent to the ER for a full assessment. Record review of Resident #1's physician order dated [DATE] read, may use [mechanical] lift for all transfers. Record review of Nursing note dated [DATE]: authored by LVN B read, called to resident [# 1's] room, resident noted laying in supine [laying face upward] position on top of [mechanical lift] sling, resident assessed, c/o[complaining of] lower back pain, MD notified, and emergency services notified to transfer to [local] hospital, RP made aware, staff by resident's side until picked up by EMS. Record review of Resident #1's Event Nurses Note authored by LVN B dated [DATE] reflected: the mechanical lift tilted during a one-person transfer by CNA A. Resident#1 had lower back pain from the fall. Resident was evaluated and sent to ER for further assessment. Record review of CNA A's written statement dated [DATE] reflected: CNA A attempted a 1-person mechanical lift of Resident #1 from bed to Geri-chair. During the attempted transfer the [mechanical lift] was flipping over towards me and the pt. Due to the pt being in the sling while it was falling over. She was between the wall and [Geri] chair. Record review of CNA C's [employee no longer employed in the facility] written statement undated reflected: CNA C went into Resident #1's room at the time of the incident [[DATE] at 4:30 PM] and saw Resident #1 on the floor with the [mechanical lift] pad under her . [CNA A] kept saying 'the [mechanical lift] flipped over'. CNA C stated that Resident #1 complained of back pain. Further, CNA C stated that when EMS arrived Resident #1 complained of back pain and Being Cold. Record review of Resident #1's ER report dated [DATE] read: CT Lumbar Spine [Without] contrast. Record review of Resident #1's hospital record dated [DATE] read: No definitive evidence seen for acute fracture or dislocation. During a telephone interview on [DATE] at 9:00 AM, CNA A stated: prior to Resident #1 having a fall from the 1-person attempted mechanical lift on [DATE] she had received an in-service on mechanical lift safety and not attempting a mechanical lift by one staff member on [DATE]. CNA A stated she was in a hurry to prepare the resident (Resident #1) for breakfast and did not wait for staff assistance. CNA A stated she prepared Resident # 1 for mechanical lift from bed to Geri-chair. CNA A stated that the resident lost her balance and the [support] bar hit the resident's head during the controlled fall. CNA A stated, I thought I could do it by myself .I should have waited for help .I blame myself. CNA A stated she was terminated for having attempted a 1-person mechanical lift. CNA A stated that she was aware that Resident #1 required a 2-person assistance during a mechanical lift. (continued on next page)		

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 10/25/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:43 AM, the DON stated: CNA A attempted a one-person mechanical lift of Resident #1 on [DATE] and the resident fell to the ground and had pain based on the written statement by LVN B. The DON stated that CNA A was trained on [DATE] after she witnessed a fall by Resident #1, on mechanical lift safety and the requirement was that it be 2-person assistance. The DON stated that Resident #1 required a 2-person mechanical lift. The DON stated she could not give an explanation why CNA A attempted a 1-person transfer when the resident required a 2-person assisted mechanical lift and CNA A was trained and competent. The DON stated, after the incident the nursing staff was in-serviced on mechanical lift safety; and CNA A was suspended and eventually terminated. The DON stated there was adequate staff available to assist CNA A during the time of the incident. The DON stated that CNA A was in-serviced on safety transfer by the Rehab Director after Resident #1's fall on [DATE]. The DON stated that CNA A attended the in-service on safe transfers given to all nursing staff after the fall on [DATE]. During a telephone interview on [DATE] at 9:55 AM, LVN B stated: Resident #1 was on the floor on [DATE] and was assessed. LVN A stated Resident #1 had no pain but was sent to the ER for evaluation due to the fall. LVN B stated that nursing staff never should attempt a 1-person mechanical lift for a 2-person assistance, because it could result in an accident. LVN B stated she had no explanation why CNA A attempted a 1-person assistance for a resident that required 2-person assistance. LVN B stated there was adequate staff available to assist CNA A during the time of the incident on [DATE]. During interview on [DATE] at 2:30 PM, DON stated concerning the fall on [DATE], Resident #1 had a witnessed fall while being assisted by CNA A in her room by use of a gait belt. The DON stated, Resident #1 was assessed and sent to ER for evaluation, with no negative findings. The DON stated interventions put in place included: referring the resident to therapy for an assessment. The DON stated that after the fall on [DATE] the resident's transfer assistance was changed to 2- persons and CNA A was aware of the change. The DON stated that the manufacture recommendation for the mechanical lifts used by the facility was a 2-person assistance. During an interview on [DATE] at 4:00 PM, the Rehab Director stated that she gave CNA A one on one in-service on safe transfers and never to transfer a 2-person mechanical lift alone. The Rehab Director stated CNA A did an improper transfer of Resident #1 on [DATE] because CNA A held the gait belt in front of the resident rather than behind the resident. The Rehab Director stated that CNA understood the training given to her on safety involving the mechanical lift and the importance of a 2-staff transfer. The Rehab Director could not give an explanation as to why a week later after being trained on mechanical lift safety, CNA A attempted a 2-person transfer by herself resulting in Resident #1 falling from the mechanical lift on [DATE]. Fall: [DATE]: Record review of facility's in-service training on [DATE] on Safe Patient Handling, Moving A Resident, Bed to Chair/Chair to Bed, and Phase 2 Competencies for Aides, reflected 16 signatures to include CNA A. Record review of CNA A's statement dated [DATE] read: Pt was walking with her walker towards her wheelchair. She had somehow got the wheel of her walker between the wheelchair and her recliner. I was holding on to her arm and stated to her to take a few steps back. She complied and took a few steps backward and then she somehow lost her balance. I had my hand on her at all times. (continued on next page)		

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 10/25/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's investigation file dated [DATE] reflected. Resident #1 had a witnessed fall on [DATE] at 2:13 PM in her room witnessed by CNA A. Resident was sent to ER for an evaluation. In-service training on safe transfers for nursing staff was started on [DATE] with CNA A signing the in-service training sheet. Record review of Resident #1's skin assessment dated [DATE] reflected the resident had a bruise dark in color to the right hand and thumb from the fall. Record review of Resident #1's Radiology Report dated [DATE] read: .Exam: CT Cervical Spine. No Acute Fractures OR Traumatic Malalignment of the Cervical Spine. Also, the CT scan dated [DATE] reflected no bleeding in the brain. Verification of PNC Fall: [DATE]: Observation on [DATE] at 11:00 AM and [DATE] at 3:00 PM of two mechanical lifts reflected they were properly done. Record review of Resident #1's neuro-check form [DATE] reflected neuro checks started at time of fall and continued after the resident returned on [DATE] from hospital at 7:45 AM; continued to [DATE] and stopped at 4:45 PM. Record review of Resident #1's Event Nurses Note authored by LVN B dated [DATE] reflected, an assessment of Resident #1 was completed, and the resident was sent to ER for an evaluation. Resident had lower back pain. Record review of sign-in sheets on the in-service training to all staff related to Abuse and Neglect and for nursing staff Safety Transfer for a Two Person mechanical lift reflected the training was completed from [DATE] to [DATE]. Completion rate was 100%. Total staff on payroll on [DATE] was 52 of which there were 30 nursing staff. Record review of CNA A's employee file reflected that on [DATE] she was rated as competent in transfers to include 1 person assist, 2- person assist, and mechanical Lift-2 person assist. Also, file reflected that CNA A was terminated [DATE] for not following the facility's policies and procedures on mechanical lift transfers. Record review of facility's investigation dated [DATE] reflected: incident occurred on [DATE] at 4:30 PM when CNA A attempted a 1-person two-person mechanical lift of Resident #1. The facility report stated that CNA A did not follow proper procedure in a 2-person transfer and was trained multiple times and was aware of the requirement. Facility substantiated [CNA A] neglected to follow [policy and procedure] as set forth and trained by the facility which resulted in Resident injury. The facility's investigation finding was confirmed. Record review of Resident #1's hospital x-ray report dated [DATE] reflected no fractures or dislocation. [CT scan was not performed on [DATE] but was done on [DATE] for the fall on [DATE]]. (continued on next page)		

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 10/25/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interview on [DATE] at 3:30 PM, Hospice MD stated that death of Resident #1 on , d+[DATE] was not related to fall on [DATE]. The MD stated the cause of death was heart failure. During interviews on [DATE] from 4:00 PM to [DATE] at 11:00 AM of 8 Shift 1 (6 AM-6 PM) staff (1 RN, 3 LVN, 4 CNA) and 8 Shift 2 staff (10 PM-6AM) (4 LVN, 3 CNA, and 1 NA) staff reflected return demonstration on mechanical lift safety measures and the importance of a 2-person assist with a mechanical lift. Record review of facility's policy entitled Safe Patient Handling, dated revised [DATE], read, .Nurses will assess the risks associated with lifting, transferring, repositioning or movement assistance . Record review of facility's policy entitled: Hydraulic Lift undated read, .The resident will achieve safe transfer to bed or chair via a mechanical lift [device] . Record review of facility's policy entitled Abuse/Neglect, dated [DATE], read, .Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .		