

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/12/2026
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a medication error rate was not 5 percent or greater. The facility had a medication error rate of 17.65%, based on 6 errors out of 34 opportunities, which involved 3 of 6 residents (Residents #5, #25 and #43) and 1 of 4 staff (DON) reviewed for medication administration reviewed for medications errors. The facility failed to ensure the DON administered medications to Residents #5, #25 and #43 timely and according to physician order. This deficient practice could place residents at risk of not receiving therapeutic effects of their medications and possible adverse reactions. The findings include: 1. A record review of Resident #5's admission record, dated 2/12/2026, revealed an admission date of 12/25/2025. Resident #5 had diagnoses which included gastro-esophageal reflux disease (GERD a chronic, severe form of acid reflux that occurs when stomach contents frequently flow back into the esophagus) and bronchitis (the inflammation of the lining of the bronchial tubes, which carry air to and from the lungs, causing symptoms like a persistent cough, mucus production, chest tightness, and fatigue). A record review of Resident #5's quarterly MDS assessment, dated 12/28/2025, revealed Resident #5 was a [AGE] year-old female who was admitted for long term care. Resident #5 was assessed with a BIMS score of 8 out of a possible score of 15, which indicated mildly impaired cognition. A record review of Resident #5's care plan, dated 2/12/2026, revealed, The Resident has GERD . the resident has shortness of breath . administer medications as ordered by physician. A record review of Resident #5's physicians orders, dated 2/12/2026, revealed the physician prescribed: benzonatate 100 MG Oral Capsule for cough (a prescription non-narcotic medication used to treat coughs caused by colds, bronchitis, or influenza by numbing the lungs and air passages to reduce the urge to cough) three times a day at 8:00 AM, 5:00 PM, and again at 9:00 PM. Maalox Max Oral Suspension 400mg aluminum -400mg magnesium -40mg simethicone every 5ML. Give 5 ml by mouth two times a day related to gastro-esophageal reflux disease without esophagitis at 6:30 AM and again at 4:30 PM. Sucralfate Oral Tablet 1 GM, Give 1 tablet by mouth before meals and at bedtime related to gastro-esophageal reflux disease without esophagitis. During an observation on 2/11/2026 at 9:55 AM, revealed the DON prepared and administered Resident #5's medications which included: benzonatate 100 MG Oral Capsule scheduled at 8:00 AM and 55 minutes late. Maalox Max Oral Suspension 400mg aluminum -400mg magnesium -40mg simethicone every 5ML. Scheduled at 6:30 AM and given 2 hours and 25 minutes late. Sucralfate Oral Tablet 1 GM, was Given after breakfast. 2. A record review of Resident #25's admission record, dated 2/12/2026, revealed an admission date of 8/7/2022. Resident #25 had a diagnosis which included Guillain-Barre Syndrome (a rare, acute autoimmune disorder where the immune system mistakenly attacks the peripheral nerves, causing rapid-onset weakness, numbness, and tingling, often beginning in the legs and moving upwards). A record review of Resident #25's quarterly MDS assessment, dated 12/4/2025, revealed Resident #25 was an [AGE] year-old male who was admitted for long term care. Resident #25 was assessed with a BIMS score of 14 out of a possible 15, which indicated no cognitive impairment. A record review of Resident #25's physicians orders, dated 2/12/2026, revealed Resident #25 was prescribed gabapentin (a nerve pain medication used to treat nerve pain) 400mg three times at 8:00 AM, 2:00 PM, and again at 8:00 PM related to (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nerve pain. A record review of Resident #25's care plan, dated 2/12/2026, revealed The resident has an alteration in neurological status related to disease process Guillain-Barre Syndrome a rare disorder in which your body's immune system attacks your nerves. Weakness and tingling in your extremities are usually the first symptoms. These sensations can quickly spread, eventually paralyzing your whole body . Give medications as ordered . During an observation on 2/11/2026 at 10:57 AM revealed the DON prepared and administered Resident #25's medications which included gabapentin 400mg which was administered at 10:57 AM, 1 hour and 57 minutes late. 3. A record review of Resident #43's admission record, dated 2/12/2026, revealed an admission date of 2/5/2026. Resident #43 had diagnoses which included type II diabetes (a chronic metabolic disorder occurring when the body becomes resistant to insulin or fails to produce enough of it, leading to high blood sugar levels) and end stage renal disease (the final, irreversible stage where kidneys function at less than 15% of normal capacity, failing to adequately filter waste and excess water from the blood.) A record review of Resident #43's admission MDS assessment, dated 2/5/2026, revealed Resident #43 was a [AGE] year-old female who was admitted for long term care related to end stage renal disease. A record review of Resident #43's physicians orders, dated 2/12/2026, revealed Resident #43 was prescribed:Sevelamer carbonate (used to control high phosphorus levels in adults with chronic kidney disease on dialysis) oral tablet 800mg, give 1 tablet by mouth three times a day for type 2 DM *give with meals. Gabapentin oral capsule 100mg. Give 1 capsule by mouth three times a day, at 7:30 AM, 12:00 PM, and again at 5:00 PM, related to type 2 diabetes. A record review of Resident #43's care plan, dated 2/12/2026, revealed The resident needs dialysis . The resident has diabetes mellitus . diabetes medications as ordered by doctor. During an observation on 2/11/2026 at 10:31 AM, revealed the DON prepared and administered Resident #43's medications which included:Sevelamer carbonate 800mg scheduled before meals and administered after breakfast at 10:31 AM.Gabapentin 100mg scheduled at 7:30 AM and administered at 10:31 AM, 2 hours late.During an interview on 2/11/2026 at 11:15 AM, the DON stated she received notice that 2 nurses would not be coming to work due to circumstances beyond their control. The DON stated the nurses were scheduled to work on 2/11/2026 from 6:00 AM to 6:00 PM. The DON stated she assumed the duty of medication administration and was running behind. The DON stated the expectation was for residents to receive their medications as prescribed and within an 1-hour window prior to and after the prescribed time. The DON stated she was responsible for residents receiving their medications on time. The DON stated the potential negative outcome for residents was that they might not receive the therapeutic effects of their medications. A Record review of the facility's, undated, policy titled Medication Administration and General Guidelines revealed, Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication . Medications are administered in accordance with written orders of the attending physician . Adheres to the 6 Rights of Medication Administration:1) Right Dose2) Right Route3) Right Resident4) Right Medication5) Right Time6) Right Documentation .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 8 residents (Residents #10, #22 and #36) and 1 of 1 facility (the facility) reviewed for infection prevention and control measures. 1. The facility failed to ensure CNA C cleaned the urinary collection tube from Resident #10s indwelling catheter.2. The facility failed to ensure CNA C did not place Resident #10's urinary collection bag on the bed and on the floor.3. The facility failed to ensure CNA B followed infection control protocols while delivering Resident #22 and Resident #36's lunch meals. 4. The facility failed to ensure there was a physical barrier between the dirty laundry area and the clean laundry area. 5. The facility failed to ensure clean mops, rags, and new linens were stored in the dirty laundry area. These failures could place residents at risk of potential harm due to cross contamination of germs and pathogens.The findings include: 1. A record review of Resident #10's admission record, dated 2/12/2026, revealed an admission date of 10/10/2024. Resident #10 had diagnoses which included hemiplegia and hemiparesis affecting the right side (result from damage to the left hemisphere of the brain, often due to stroke, tumors, or injury. Causing reduced motor control, strength, and mobility in the right arm, leg, and sometimes face), retention of urine (when not all the urine is expelled), and history of urinary tract infections. A record review of Resident #10's quarterly MDS assessment, dated 1/14/2026, revealed Resident #10 was a [AGE] year-old male who was admitted for long term care related to supports with ADL care. Resident #10 was assessed with a BIMS score of 15 out of a possible score of 15, which indicated no cognitive impairment. A record review of Resident #10 physicians' orders, dated 2/12/2026, revealed on 1/30/2026 Resident #10 was ordered to receive an indwelling urinary catheter and support for the catheter; change if occluded, or closed system was compromised, or leaking. The physician ordered for the urinary catheter system would be monitored for leakage, blockage, sediment buildup, or low output. A record review of Resident #10's care plan, dated 2/12/2026, revealed the care plan was revised on 2/9/2026 and again 2/11/2026 after state surveyor interventions, The resident has urinary tract infection . provide incontinence care as needed . The resident is on enhanced barrier precautions . The resident has urinary retention . provide catheter care. During an interview on 2/10/2026 at 4:10 PM, Resident #10 stated he was concerned about developing another urinary tract infection. Resident #10 stated he had a previous urinary retention and was hospitalized in late January 2026 for a UTI and was diagnosed with sepsis related to urinary retention. Resident #10 stated he was prescribed antibiotics and an indwelling urinary catheter. Resident #10 stated he was discharged from the hospital on 1/30/2026 and admitted back into the facility the same day. Resident #10 stated since he had been in the facility with the indwelling urinary catheter, staff had not used gowns nor gloves when performing his urinary catheter care. Resident #10 stated he observed staff raise his urine collection bag higher than his waist and had not cleaned his catheter collection tube. During an observation and interview on 2/10/2026 at 8:30 PM revealed Resident #10 in his room seated in his wheelchair. Resident #10 presented with his urinary catheter secured under the wheelchair and contained reddish colored urine. CNA C donned PPE to include gloves, gown and assisted Resident #10 to transfer from wheelchair to his bed. When Resident #10 was in bed CNA C assisted Resident #10 to disrobe and while removing Resident #10's pants CNA C held the urine collection bag above the resident's abdomen / bladder. CNA C then placed the urine collection bag on the bed. During the incontinent care episode CNA C failed to clean Resident #10's catheter tubing, failed to retract Resident #10's foreskin to clean the meatus. After Resident #10's incontinent care, CNA C placed the urine collection bag on the floor prior to emptying the urine into a collection bottle for disposal. CNA C stated she raised the urine collection bag above the abdomen, did not clean the catheter tubing and placed the urine collection bag on the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed and then on the floor. CNA C stated she received training for indwelling urinary catheter care and stated she did not know a potential negative outcome by the care provided. 2. During an observation on 2/9/2025 at 12:15 PM revealed CNA B assisted in the dining room when he collected residents' meals on a meal tray delivery cart and then delivered those meals by removing individual meal trays and delivered the meals to each resident. CNA B was observed to not perform hand hygiene in between residents specifically while he delivered a lunch meal to Resident #22 and did not perform hand hygiene and then proceeded to deliver a lunch tray to Resident #36. During an interview on 2/9/2026 at 12:15 PM, CNA B stated he did not recognize he had not practiced hand hygiene in-between delivering meal trays to residents. CNA B could not state any potential negative outcome by not performing hand hygiene in between serving each resident. CNA B stated he did recall he was supposed to perform hand hygiene and may have just made a mistake. 3. During an observation and interview on 2/10/2026 at 9:40 AM revealed the laundry department consisted of 3 main rooms: The entry room to the dirty laundry area, The dirty clothes washer room, The clean dryer room and clean clothes storage room. Further observation revealed there was no physical separation between the dirty washer room and the clean clothes dryer room. The area consisted of a plain doorway without a door and or means of separation. There were clean mops, rags and new bed linens stored in the entrance room to the dirty washroom. Laundry Aide E (LA E) stated the laundry department consisted of 3 main rooms, the dirty entrance laundry area, the washer room, and the clean clothes side. LA E stated clean housekeeping mops, wash rags and new blankets were stored in the entrance room on the dirty side. LA E stated the mop heads and rags were stored there for them to dry. LA E stated the blankets were new and were available for staff, but the staff should not take them because they needed to wash them before staff could use them. LA E stated there was no separation between the clean dryer room and the dirty washroom. During an observation and interview on 2/10/2026 at 10:08 AM revealed Housekeeper F (HK F) was cleaning and mopping Resident #15's room and Resident #20's room. HK F stated she cleaned mops and rags she retrieved from the janitor's closet in the facility. HK F stated she stocked the janitors closet with clean mop heads and rags she collected from the drying rack in the laundry department's 1st entry room. HK F stated the room was in the dirty side, but the mops and rags were clean. During an interview on 2/11/2026 at 5:45 PM, the DON stated infection prevention and control measures were developed and implemented with the staff and were often reviewed. The DON stated the expectation for staff who delivered meals to residents was for hand hygiene in-between serving each resident. The DON stated indwelling catheter care consisted of hygienic procedures per professional standards which included cleaning the catheter tubing and never placing the urinary collection bag on the floor nor on the bed. The DON stated CNA C was provided with indwelling urinary catheter care and demonstrated proficiency. The DON stated the potential negative outcome could be cross contamination of germs to residents and staff. During an interview on 2/12/2026 at 5:50 PM, the Administrator stated she concurred with the DON and the issues in the laundry department would be corrected and the DON would ensure infection prevention and control measures would be reviewed and re-enforced. A record review of the facility's, undated, policy titled Fundamentals of Infection Control Precautions revealed, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. 1. Hand Hygiene Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. Before and after eating or handling food (hand washing with soap and water); Before and after assisting a resident with meal. 7. Linen and laundry Although soiled linen may be contaminated with pathogenic microorganisms, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms. Hygienic and common-sense storage and processing of clean and soiled linen is recommended. 1. All soiled linen will be double bagged at the site that it was generated. All personnel will utilize appropriate personal protective equipment. 2. Soiled linen will be transported to the laundry site by CNA. 3. The soiled linen (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will be processed as per Linen protocol. A record review of the facility's, undated, policy titled Catheter Care revealed, . When the resident is ambulatory the bag must be held lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Be sure the catheter tubing and drainage bag are kept off the floor. Keep drainage bag below level of bladder when cleaning the urethral area: Gently wash, rinse and dry around the juncture of the catheter and meatus. Then wash the catheter from the meatus down the tube about 3 inches.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure within 14 days after a facility completed a resident's assessment, the facility electronically transmitted encoded, accurate, and complete MDS data to the CMS System upon a resident's transfer, reentry, discharge, and death, for 1 of 8 residents (Resident #4) reviewed for transmitted MDS data to the CMS System. The facility failed to transmit a discharge MDS assessment to the CMS system for Resident #4. This deficient practice could place residents at risk of MDS inaccuracies. Record review of Resident #4's admission Record dated [DATE] documented a [AGE] year-old male who was originally admitted to the facility [DATE] and most recently admitted on [DATE]. The diagnoses for Resident #4 included alcoholic cirrhosis of liver with ascites (liver disease with accumulation of fluid in the abdominal cavity), Type 2 diabetes mellitus with diabetic neuropathic arthropathy (a severe complication of diabetes where nerve damage leads to progressive, destructive joint degeneration), unspecified combined systolic and diastolic heart failure (a condition where the heart has both impaired contraction [(systolic)] and reduced filling [(diastolic)], preventing efficient pumping) and Alzheimer's Disease (a progressive, irreversible neurodegenerative disorder that destroys memory, thinking skills and eventually the ability to function). Record review of Resident #4's Nurses Notes revealed Resident #4 expired on [DATE] with a hospice nurse at his bedside. Record review of Resident #4's Significant Change MDS dated [DATE] in Section O K1 was checked for hospice care which indicated he was admitted to hospice care within the last 14 days. There was no documentation of a Discharge MDS for Resident #4. During an interview with the MDS Coordinator on [DATE] at 5:26 pm, she stated she failed to complete a Discharge MDS following Resident #4's death. The MDS Coordinator stated it was important to complete all required MDS Assessments so CMS would have accurate information regarding residents in long term care. Record review of the facility's MDS Transmission policy stated: All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. --Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care and was developed within 48 hours of a resident's admission for 1 of 8 residents (Resident #10 reviewed for baseline care plans. 1. The facility failed to ensure Resident #10's baseline care plan reflected the residents immediate need for support with an indwelling urinary catheter. 2. The facility failed to ensure Resident #10's baseline care plan was developed within 48 hours of admission. These failures could place residents at risk of a decline in health status. The findings include: A record review of Resident #10's admission record, dated 2/12/2026, revealed an admission date of 10/10/2024. Resident #10 had diagnoses which included hemiplegia and hemiparesis affecting the right side (result from damage to the left hemisphere of the brain, often due to stroke, tumors, or injury. Causing reduced motor control, strength, and mobility in the right arm, leg, and sometimes face), retention of urine (not all urine is expelled), and history of urinary tract infections. A record review of Resident #10's quarterly MDS assessment, dated 1/14/2026, revealed Resident #10 was a [AGE] year-old male who was admitted for long term care related to supports with ADL care. Resident #10 was assessed with a BIMS score of 15 out of a possible score of 15, which indicated no cognitive impairment. A record review of Resident #10 physicians' orders, dated 2/12/2026, revealed on 01/30/2026, the physician prescribed Resident #10 would receive an indwelling urinary catheter and support for the catheter; change if occluded, or closed system was compromised, or leaking. The physician ordered for the urinary catheter system to be monitored for leakage, blockage, sediment buildup, or low output. A record review of Resident #10's baseline care plan, dated 1/30/2026, revealed the baseline care plan did not have any focuses, goals, or interventions for Resident #10's indwelling urinary catheter. A record review of Resident #10's care plan, dated 2/12/2026, revealed the care plan had been revised on 2/9/2026 and again on 2/11/2026 after state surveyor interventions, The resident has urinary tract infection . provide incontinence care as needed . The resident is on enhanced barrier precautions . The resident has urinary retention . provide catheter care. During an interview on 2/10/2026 at 5:55 PM, LVN D stated Resident #10 had a recent hospitalization related to a UTI and had returned with a urinary catheter on 1/30/2026. LVN D stated Resident #10 had a care plan for an indwelling urinary catheter and it was updated 2/9/2026. During an interview on 2/10/2026 at 4:10 PM, Resident #10 stated he was concerned about developing another urinary tract infection. Resident #10 stated he had a previous urinary retention and had been hospitalized late January 2026 for a UTI and was diagnosed with sepsis related to urinary retention. Resident #10 stated he was prescribed antibiotics and an indwelling urinary catheter. Resident #10 stated he was discharged from the hospital on 1/30/2026 and admitted back into the facility the same day. Resident #10 stated since he had been in the facility with the indwelling urinary catheter staff had not used gowns nor gloves when performing his urinary catheter care. Resident #10 stated he had observed staff to raise his urine collection bag higher than his waist and had not cleaned his catheter collection tube. During an observation and interview on 2/10/2026 at 8:30 PM revealed Resident #10 in his room seated in his wheelchair. Resident #10 presented with his urinary catheter secured under the wheelchair which contained reddish colored urine. CNA C stated she was prepared to provide Resident #10 incontinent and catheter care. CNA C stated she had a care plan Kardex where she documented the care under ADL care. During an interview on 2/11/2026 at 5:45 PM, the DON stated upon admission residents were reviewed for a baseline care plan and she (the DON) would review the new admission the next day along with the IDT and would ensure the residents immediate needs for care would be developed and implemented within 48 hrs. of admission. The DON stated the potential negative outcome could be that indwelling catheter (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care would not have been care-planned within the 48 hours from admission. A record review of the facility's, undated policy titled Base Line Care Plans revealed, Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will- Be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-o Initial goals based on admission orders.o Physician orders.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 8 residents (Resident #9) reviewed for care plans. The facility failed to ensure Resident #9's prescribed diet for a regular diet texture with finger foods and ground textured meats, were reflected in the residents care plan. This failure could place residents at risk for a decline in their health status. The findings include: A record review of Resident #9's admission record, dated 2/10/2026, revealed an admission date of 12/20/2025. Resident #9 had diagnoses which included Parkinson's disease (a progressive, neurodegenerative brain disorder caused by the loss of dopamine-producing neurons, leading to motor symptoms like tremors, stiffness, bradykinesia [slowness of movement], and walking/balance issues), functional quadriplegia (a condition of complete immobility in all four limbs caused by severe physical debility or illness, without injury to the brain or spinal cord) and dysphagia (difficulty swallowing). A record review of Resident #9's quarterly MDS assessment, dated 12/24/2025, revealed Resident #9 was an [AGE] year-old female and was admitted for long term care with supports for safe assistance with ADL. Resident #9 was assessed with a BIMS score of 04 out of a possible 15, which indicated severely impaired cognition. A record review of Resident #9's physician orders, dated 2/10/2026, revealed the physician prescribed on 12/22/2025 for Resident #9 to receive a regular diet with finger foods and ground texture meats. A record review of Resident #9's care plan, dated 2/10/2026, revealed no focus, goal, or interventions for Resident #9's need for ground meats. During an observation on 2/11/2026 at 5:20 PM revealed Resident #9 seated in her wheelchair at the dining room table and was being assisted to eat her dinner meal by RN A. Resident #9 was served ground buffalo chicken. During an interview on 2/11/2026 at 5:30 PM, RN A stated Resident #9 was served finger foods and ground meats as prescribed by the physician and SLP. During an interview on 2/11/2026 at 5:45 PM, the DON stated the care plan should be revised after any new physicians' orders, such as a diet texture change. The DON stated residents were receiving the care specified in their orders, however, the care plan had not been revised to accurately reflect the care provided. The DON stated she was responsible for reviewing any new orders and would ensure the care plan reflected the new orders. The DON stated the potential negative outcome could be their care plan would not be accurate. A record review of the facility's, undated, policy titled Comprehensive Care Planning revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 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 02/12/2026
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 8 residents (Resident #10) reviewed for urinary catheter care. The facility failed to ensure CNA C performed urinary catheter care for Resident #10 according to professional standards. This failure could place residents at risk for a decline in health status. The findings include: A record review of Resident #10's admission record, dated 2/12/2026, revealed an admission date of 10/10/2024. Resident #10 had diagnoses which included hemiplegia and hemiparesis affecting the right side (result from damage to the left hemisphere of the brain, often due to stroke, tumors, or injury. Causing reduced motor control, strength, and mobility in the right arm, leg, and sometimes face), retention of urine (not all the urine is expelled), and history of urinary tract infections. A record review of Resident #10's quarterly MDS assessment, dated 1/14/2026, revealed Resident #10 was a [AGE] year-old male who was admitted for long term care related to supports with ADL care. Resident #10 was assessed with a BIMS score of 15 out of a possible score of 15, which indicated no cognitive impairment. A record review of Resident #10 physicians' orders, dated 2/12/2026, revealed on 01/30/2026 the physician prescribed Resident #10 would receive an indwelling urinary catheter and support for the catheter; change if occluded, or closed system was compromised, or leaking. The physician ordered for the urinary catheter system to be monitored for leakage, blockage, sediment buildup, or low output. A record review of Resident #10's care plan, dated 2/12/2026, revealed the care plan, dated 2/11/2026, revealed no interventions for Resident #10's UTI, need for UTI EBP, need for incontinent care related to his indwelling urinary catheter with diagnosis of urinary retention. A record review of Resident #10's care plan, dated 2/12/2026, revealed the care plan was revised on 2/9/2026 and again 2/11/2026 after state surveyor interventions, The resident has urinary tract infection . provide incontinence care as needed . The resident is on enhanced barrier precautions . The resident has urinary retention . provide catheter care. A record review of Resident #10's hospital discharge report, dated 1/30/2026, revealed resident #10 was admitted and treated for a UTI. During an interview on 2/10/2026 at 4:10 PM, Resident #10 stated he was concerned for developing another urinary tract infection. Resident #10 stated he had a previous urinary retention and was hospitalized in late January 2026 for a UTI and was diagnosed with sepsis related to urinary retention. Resident #10 stated he was prescribed antibiotics and an indwelling urinary catheter. Resident #10 stated he was discharged from the hospital on 1/30/2026 and admitted back into the facility the same day. Resident #10 stated since he has been in the facility with the indwelling urinary catheter staff had not used gowns nor gloves when performing his urinary catheter care. Resident #10 stated he observed staff raise his urine collection bag higher than his waist and had not cleaned his catheter collection tube. During an observation and interview on 2/10/2026 at 8:30 PM revealed Resident #10 in his room seated in his wheelchair. Resident #10 presented with his urinary catheter secured under the wheelchair and it contained a reddish colored urine. CNA C donned PPE to include gloves, gown and assisted Resident #10 to transfer from the wheelchair to his bed. When Resident #10 was in bed CNA C assisted Resident #10 to disrobe and while removing Resident #10's pants, CNA C held the urine collection bag above the resident's abdomen / bladder. CNA C then placed the urine collection bag on the bed. During the incontinent care episode, CNA C failed to clean Resident #10's catheter tubing and failed to retract Resident #10's foreskin to clean the meatus. After Resident #10's incontinent care, CNA C placed the urine collection bag on the floor prior to emptying the urine into a collection bottle for disposal. CNA C stated she raised the urine collection bag above the abdomen, did not clean the catheter tubing and placed the urine collection bag on the bed and then on the floor. CNA C stated she received training for indwelling urinary catheter care and she did not know (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER LA Bahia Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 225 E Ward St Goliad, TX 77963	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a potential negative outcome by the care provided. During an interview on 2/11/2026 at 5:45 PM, the DON stated catheter care was expected at every incontinent care episode and at a minimum per physicians' orders every shift. The DON stated indwelling catheter care consisted of hygienic procedures per professional standards which included cleaning the catheter tubing. The DON stated CNA C had been provided with indwelling urinary catheter care and had demonstrated proficiency. The DON stated the potential negative outcome could be indwelling catheter care not performed per training and professional standards. A record review of the facility's, undated, policy titled Catheter Care revealed, . When the resident is ambulatory the bag must be held lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Be sure the catheter tubing and drainage bag are kept off the floor. Keep drainage bag below level of bladder when cleaning the urethral area: Gently wash, rinse and dry around the juncture of the catheter and meatus. Then wash the catheter from the meatus down the tube about 3 inches.		