STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675891	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeport Medical Lodge	2108 15th Street Bridgeport, TX 76426

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, and exploitation for one (Resident #1) of 3 residents reviewed for abuse. The facility failed to protect Resident #1 from being abused by CNA A, who, through video-footage, was observed to be physically rough with Resident #1 during incontinent care, was verbally aggressive, and had struck Resident #1 across the forehead. The noncompliance was identified as PNC. The PNC began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the investigation began. This failure could result in resident abuse, psychosocial harm, and physical injuries.Findings included:Record review of Resident #1's admission record dated [DATE] revealed an 82- year-old female with an Initial admission Date of [DATE] and re-admission date of [DATE]. Resident #1 had the following diagnoses: Other Lack of Coordination (primary diagnosis), Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, Alzheimer's disease, anxiety disorder, and need for assistance with personal care. Advance Directive; DNR. Record Review of Resident #1's Care Plan undated revealed: Admit to SNF D/T self care deficit, will optimize the autonomy and independence of this resident to safely preform self care activities. assist as needed in aspects of self care that are problematic to resident. Electronic Monitoring Electronic Monitoring /Camera in room per resident and family request - managed by family R/T resident dignity will be maintained and protected through next AEB no documented or reported breach to provision of resident dignity. care will be met and uninterrupted via camera use. keep sign posted at all times on door of room regarding electronic monitoring. Resident has an ADL self-care performance deficit r/t Dementia, BATHING: Resident requires assistance with bathingBED MOBILITY: Resident requires assistance with bed mobility.DRESSING: Resident requires assistance with dressing.Record review of Quarterly Minimum Data Set, dated [DATE] revealed; BIMS score of 99 (resident was unable to completed the interview). Section GG- Functional Abilities E- Shower/bathe self- Substantial/maximal assistance F. upper body dressing-Substantial/maximal assistance; G Lower body dressing- Mobility: A. Roll left and right-Dependent-Helper doe ALL of the effort. Substantial/Maximal assistance Record review of resident #1's order Summary Report dated [DATE]-[DATE] revealed; Skull 3v/ Hand Rt 2v sent for imaging [DATE] 12:12 PM CT one time only related to Pain Unspecified wi/c patient. Psychological Services, ordered [DATE]. Review of the facility's provider investigation report, dated [DATE], revealed Resident #1's family member witnessed CNA A, the alleged perpetrator, striking Resident #1 in the face while providing ADL care. Resident was found with bruising on right hand measuring 4.6 x 2.5 x 0.1 cm. There was mild swelling to the left side of the face. Results of x-ray for left side of the face came back cleared. CNA A was removed from the facility and the agency company was contacted. Safe rounds were performed on all residents under CNA A's care. All residents reported feeling safe. The family, physician, ombudsman, and police were all notified. Review of in-room video, undated, revealed a 40 second clip which showed Resident #1 lying in bed with mechanical lift sling under her body, CNA A standing next to the bed. CNA A rolled Resident #1 away from her (Resident #1 is on her left side) toward the wall and adjusted her pants. CNA A then rolled Resident #1 back towards her (Resident #1 is being rolled back to her right side) grabbed her wrist and pulled her over. At 0:13 seconds CNA A was heard saying Save those fake-ass tears, you weren't trying to cry before you hit me. CNA A was observed lifting Resident #1's head up and adjusting the nightgown. At 0:21 seconds, Resident #1 was lying in bed with top part of her body exposed, CNA A used a body wipe to clean under the right armpit and crossed over Resident #1's body to wipe left armpit area. At 0:33 seconds, CNA A lifted Resident #1's head to place shirt over head when Resident #1 used her left hand to hit CNA A on her right forearm. CNA A then used her right hand and hit Resident #1 on the left side of her forehead (audible sound of hand making contact with flesh) and said Stop. Video ends at 0:40 seconds. Interview with Resident #1 could not be conducted. Resident #1 had expired, unrelated to the incident, on [DATE].Attempted interview on [DATE] at 2:14 PM, with CNA A revealed no answer to phone call to last known number, voicemail left with call back number. Interview on [DATE] at 2:18 PM, the Agency Director revealed, CNA A was not an employee but an independent contractor with his agency. Her access to the platform was removed on [DATE]. She was disqualified from accepting any positions. Background checks and abuse/neglect training was verified by agency. Interview on [DATE] at 4:10 PM, the DON revealed she was notified of the alleged abuse of Resident #1 via a call from the resident's family member. The family member informed both the