STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/01/2026
NAME OF PROVIDER OR SUPPLIER Matagorda Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4521 Ave F Bay City, TX 77414	

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 - Immediate jeopardy to resident health or safety 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** Based on observation, interview, and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of five residents reviewed for accidents hazards and supervision, in that: CNA A failed to perform an appropriate Hoyer Lift transfer with two staff as required, which resulted in Resident #1 sustaining a fall with head injury on 12/30/2025.Resident #1 was transferred from Local Hospital A to City Hospital B's Neuroscience ICU with a diagnosis of a brain bleed and subdural hematoma with subarachnoid hemorrhaging on 12/30/2025. An IJ was identified on 12/31/25. The IJ template was provided to the facility on [DATE] at 4:20 pm. While the IJ was removed on 1/1/26, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor the implementation of the plan of removal. The failure could place residents at risk of experiencing accidents, injuries, and/or death. The findings included:Record review of Resident #1's face sheet revealed an eighty-three-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were dementia (Dementia is the loss of cognitive functioning that interferes with daily life and activities), heart failure, and morbid obesity (a BMI of 40 or higher). Record review of Resident #1's care plan revealed that she had an ADL self-care performance deficit. Interventions required the use of a Hoyer lift with 2 people (dated 3/4/25), and she was a 2 staff total assist for all transfers and bed mobility. Record review of Resident #1's weights and vitals dated 12/8/25 revealed that she was 66 inches in height (5'5) and weighed 272.5 lbs. Record review of Resident #1's MDS dated [DATE] (resident assessment tool used to document a resident's clinical status, functional abilities, and care needs), Section C titled Cognitive Patterns, revealed a BIMS (cognitive assessment) score of 15 (cognitively intact). Review of Section GG Functional Abilities, subsection Mobility revealed that Resident #1 was dependent on staff for toilet transfers, tub/shower transfers, chair to bed transfers, sitting to stand, and lying to sitting on side of bed. Resident #1 utilized a wheelchair but could independently wheel 50 feet with two turns. Record review of the facility's in-service trainings from January 2025- December 2025, revealed that a Hoyer lift training was conducted on 1/6/25, 1/22/25, and 12/30/25 (completed after the incident). CNA A's name was not listed on the in-services. Record review of Resident #1's progress notes effective on 12/31/25 at 3:50 a.m., LVN B documented that Resident #1 fell from the Hoyer lift during a transfer in her room at 3:50 a.m. She sustained bleeding to the back of the head and pressure was applied to stop the bleeding. Resident #1 had complaints of continuous pain located on the back or her head, left shoulder, and left heel. She was sent to Local Hospital A by EMS at 4:35 a.m. Nurse practitioner, ADON, and FM were notified. Record review of Resident #1's Neuro Assessment progress note, effective on 12/31/25 at 3:50 a.m., LVN B documented the following:BP- 177/115. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	P-85.Eyes Opening: Spontaneously.Best Verbal Response: Oriented to person, place and time.Best Motor Response: Obeys Commands; example stick out your tongue, squeeze my hand.Pupils equal and reactive to light: YesRight Pupil (blank=assessment not required):Left Pupil (blank=assessment Record review of the Hoyer lift company service dated 12/9/25 revealed that 3 Hoyer lifts were inspected. Documentation stated that calibrations were performed on the lifts and all lifts were in good calibration and working order. In an interview on 12/30/25 at 11:54 am with the ADM, she stated that Resident #1 was admitted to Local Hospital A with a laceration to the back of her head and she provided the contact numbers for CNA A and LVN B. She stated that CNA A had been suspended that morning pending investigation. In an interview on 12/30/25 at 12:09 p.m., CNA A stated that she was hired in June 2025 and worked the 6 p.m.- 6 a.m. shift. She recalled on 12/30/2025 around 3:30 am, she began to get Resident #1 ready to get out of bed to her wheelchair using the Hoyer lift. She said although Resident #1 was a 2 person assist, she decided to perform the transfer on her own because the other aide was busy. During the transfer, she explained that the Hoyer arms that attached to the sling were wobbling and the sling on the right side slipped off the hook and Resident #1 fell straight down and hit her head. CNA A noted seeing blood on the floor and immediately notified her LVN B. She explained that she did the Hoyer transfer by herself because that's how it is at the nursing home, everybody does it by themselves. I didn't think anything bad would happen. CNA A recalled that Resident #1 was very alert and was able to communicate what was going on. She could not remember when she last received training using the Hoyer lift and stated that she might have gotten one when she was hired. In an interview on 12/30/25 at 12:25 p.m., CNA B stated that she had worked at the facility for 1 year and she worked the 6 a.m.- 6 p.m. shift. She identified that there were 2-3 people on her assigned hallway that required a Hoyer lift for transfers and the transfer should always be completed with 2 people. She stated that before she received the Hoyer lift training on the morning of 12/30/25, the last time she could recall receiving training was 4 months ago. In an interview on 12/30/25 at 12:35 p.m. with CNA C, she stated that she had worked at the facility for 6 months and she worked the 6 a.m.- 6 p.m. shift. She stated that she had 2 people on her assigned hall that required Hoyer lift transfers, and she always performed them with 2 people. She received an in-service on Hoyer lift transfers on 12/30/25 around 11:15 a.m. Prior to this in-service, she recalled the last Hoyer lift training to be in October 2025. In an interview on 12/30/25 at 12:54 p.m. with CNA D, she stated that she was hired in April of 2025 and she worked the 6 a.m. -6 p.m. shift. She stated that she was comfortable doing Hoyer lift transfers and they should always be done with 2 people and never one. Her most recent Hoyer lift transfer in-service was on 12/30/25 around 11 a.m. and her last in-service was sometime in August or September. She denied ever seeing or having knowledge of any staff members performing Hoyer lift transfers without the assistance of one or two additional people. In an observation on 12/30/25 between 1:23 p.m. and 1:35 p.m., two Hoyer lift transfers were observed with CNA B, CNA D, and CNA H. Both transfers were performed with at least 2 aides. In an interview on 12/30/25 at 1:37 p.m. with Resident #2 who resided on Hall C, she stated that she usually left her room for lunch in her wheelchair, but she did not that day. For transfers, she said that staff used the hoyer lift and it was usually done with one person. She could not recall the name of the person who did the hoyer lift transfers by themselves but stated that she called them Ms. [CNA's first name] CNA E. Record review of the facility's schedule provided 12/30/25 for 12/31/25 revealed that there was an aide named (CNA E's first name) CNA E who was assigned to work Hall C. An attempt was made on 12/30/25 at 2:30 p.m. to visit Resident #1 in Local Hospital A. Hospital receptionist (name not captured) stated that there were no residents at that hospital with that name and she could not pull up any admission (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She stated that the lift was manufactured in November 2022 but the manual was updated annually in November, with the most recent update in November 2025. In an interview at City Hospital B on 12/31/25 at 9:57 a.m. with RN A, he stated Resident #1 was admitted to City Hospital B Neuroscience ICU on 12/30/25 with diagnoses of brain bleeding and a subdural hematoma with subarachnoid hemorrhages (a life-threatening stroke from bleeding into the space between the brain and its protective membranes). He stated she was stable but was having trouble breathing. In an observation and interview on 12/31/25 at 10:02 a.m., Resident #1 laid in the bed inside the Neuroscience ICU at City Hospital B with a nasal canula in her nose and IVs hooked into her arms. She stated that she fell during a Hoyer transfer and she hit her head. She repeated several times that her head hurt and stated that she was trying to put the pieces together, but she was so weak and getting so tired. A record request was submitted to Local Hospital A and City Hospital B on 1/7/26. A follow up was sent on 1/12/25. No information has been provided at this time. Record review of the Manufactures Hoyer lift instructions, manufactured November 2022, updated annually (November 2025) reflected that at least two people should operate the Hoyer lift during transfer. The Administrator was notified of the IJ on 12/31/25 at 4:20 p.m. and given the IJ template due to the above failures and a POR was requested. On 12/31/25 at 7:36 p.m., the POR was accepted. It was documented as follows: 12/31/2025F689 Free of accident hazards/supervision/devicesPlan of Removal: The facility failed to perform an appropriate Hoyer Lift transfer with two staff as required and resulted in Resident #1 sustaining a fall with head injury on 12/30/2025.Interventions: Resident #1 was transferred to the ER for observation on 12/30/2025.All residents requiring hoyers care plans were reviewed for accuracy of transfer assistance by DON/Designee on 12/30/2025.All nursing staff in serviced on mechanical lift transfers by DON/ADON/Designee on 12/30/2025 and 12/31/2025. DON/ADON/Designee complete the training for all nursing staff for mechanical lift transfers.Employee suspended pending investigation, terminated 12/30/2025.Hoyer was taken out of commission as a precaution until third party came to assess the integrity of the hoyers. Hoyers assessed 12/30/25. No findings were identified.All hoyers were assessed by third party on 12/30/25. No findings were identified.All slings were assessed on 12/30/25 by DON/ADON/Designee. No findings were identified.Signage applied to hoyers stating Must use 2 trained staff1:1 in service with the aide who completed the transfer with insufficient staff on Resident #2, in service was completed by the DON.The Medical Director was notified of the Immediate Jeopardy on 12/31/2025 by the [NAME] ADHOC QAPI meeting was completed by the interdisciplinary team to include the Medical Director 12/30/2025.Live demonstration with staff participation during the hoyer lift in-service on 12/30/2025 and 12/31/2025. Staff not present were in-serviced via phone, and will complete live demonstrations upon return to work. The DON and ADON were in-serviced 1:1 by the ADO, Compliance Nurse on following in-services on 12/31/2025.Abuse and Neglect: The administrator is the abuse coordinator. All allegations of abuse and neglect should be reported to the administrator immediately. If you can't get ahold of the administrator, call the DON.POC Kardex: The Kardex on Point of Care is where you find the amount of assistance required to assist a resident with care.Hoyer Transfers: All residents who require the hoyer for transfers must be completed by two trained staff members. No exceptions. This is for the safety of residents and staff. Hoyer slings are to be replaced every 6 months. If a hoyer sling is frayed it must be removed from use and turned in to your supervisor. If a hoyer or any piece of equipment is malfunctioning the equipment must be removed from use by the staff member and the Administrator must be notified immediately.Falls: If you witness a resident fall or find them on the floor, notify the charge nurse immediately. If you can't find a charge nurse, call the DON or ADON immediately. You can prevent falls by making sure a resident has their walker/ wheelchair, proper footwear, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	answering the call light timely, frequent toileting, and ensuring the room is free of trip hazards.The Administrator was in-serviced 1:1 by the ADO, Compliance Nurse on following in-services on 12/31/2025.Abuse and Neglect: The administrator is the abuse coordinator. All allegations of abuse and neglect should be reported to the administrator immediately. If you can't get ahold of the administrator, call the DON.POC Kardex: The Kardex on Point of Care is where you find the amount of assistance required to assist a resident with care.Hoyer Transfers: All residents who require the hoyer for transfers must be completed by two trained staff members. No exceptions. This is for the safety of residents and staff. Hoyer slings are to be replaced every 6 months. If a hoyer or any piece of equipment is malfunctioning the equipment must be removed from use by the staff member and the Administrator must be notified immediately. In-services: The following in-services were initiated on 12/30/2025 for all staff members by the DON, ADON, Designee via phone and/or in person. All staff not in-serviced will not be permitted to work their assignment until in-serviced. All new hires will be in-serviced during facility orientation. All agency staff will be in-serviced prior working their floor assignmentAbuse and Neglect: The administrator is the abuse coordinator. All allegations of abuse and neglect should be reported to the administrator immediately. If you can't get ahold of the administrator, call the DON.POC Kardex: The Kardex on Point of Care is where you find the amount of assistance required to assist a resident with care.Hoyer Transfers: All residents who require the hoyer for transfers must be completed by two trained staff members. No exceptions. This is for the safety of residents and staff. Ensuring the residents are centered and the equipment is close by such as the wheelchair close to the bed. Hoyer slings are to be replaced every 6 months. If a hoyer sling is frayed it must be removed from use and turned into your supervisor. If a hoyer or any piece of equipment is malfunctioning the equipment must be removed from use by the staff member and the Administrator must be notified immediately.Falls: If you witness a resident fall or find them on the floor, notify the charge nurse immediately. If you can't find a charge nurse, call the DON or ADON immediately. You can prevent falls by making sure a resident has their walker/ wheelchair, proper footwear, answering the call light timely, frequent toileting, and ensuring the room is free of trip hazards.Monitoring/Verification of Plan of removal The POR was reviewed as follows. The facility created a binder and numbered each tab in the binder with the completed documentation necessary to fulfill the plan. Day 1: Thursday 1/1/26Resident #1 remained at City Hospital B on 1/1/26.A list of 11 residents who required Hoyer lift transfers was provided to the surveyor. Care plans were reviewed for accuracy. Care plans were accurate.Record review of an in-service dated 12/31/25 that covered Abuse and Neglect, POC Kardex, Hoyer Transfers, and Falls revealed that ADON, DON, and ADM were in-serviced. Record review of CNA A's termination documentation revealed that she was terminated on 12/30/25.Record review of an in-service form dated 12/31/25 revealed that CNA E received an one on one education regarding using a Hoyer lift with 2 people and if another staff member was not present, they should reach out to the charge nurse for assistance. Failure to do so could lead to falls, injury, and termination.Record review of QAPI ADHOC, titled Insufficient staff to perform a task/ADL noted the concern that an aid transferred a resident without sufficient staff. Interventions included in-servicing or all direct care staff (nurses, aides, and med aides), audits of hoyers, audits of slings, and audits of the Kardex. Contributors of the QAPI were ADM, ADON, DON, MD, social services, dietary, and activity director.Record review of the Hoyer lift company service dated 12/9/25 revealed that 3 Hoyer lifts were inspected. Documentation stated that calibrations were performed on the lifts and all lifts were in good calibration and working order.Record review of an in-service on 12/30/25 titled How to use a Kardex was conducted with all CNA's and nurses.Record review of an in-service on 12/30/25 titled (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Notifying appropriate people when equipment is defective. This in-service documented on ensuring the Hoyer sling was properly placed when completing transfers, what to do if the equipment was defective, who to inform regarding defective equipment, and how to use the QR code to notify maintenance. All nursing staff were in-serviced.Record review of an in-service on 12/30/25 titled Falls detailed what to do if you found a resident on the floor and notifying the DON and ADON immediately. All nursing staff were in-serviced.Record review of an in-service on 12/30/25 titled Abuse and Neglect reflected all nursing staff were in-serviced.On 12/30/25, HC Owner traveled to inspect the facility hoyer lifts. No issues were noted. Signage was observed and placed on all Hoyer lifts that stated must use 2 trained staff. CNA E and CNA F were observed on 1/1/26 at 3:02 p.m. performing a Hoyer lift transfer. Hoyer lift was positioned close to the bed and the wheelchair was locked during transfer. Resident was calm without distress. No issues were noted and transfer performed as detailed in facility's POR. MD was interviewed on 1/1/26 at 3:22 p.m. He agreed with the QAPI and stated that they covered which staff should be in-serviced for Hoyer lift transfers, CNAs following the Kardex, discussed if there were any staffing issues and made sure there was enough staff on shift to tend to the needs of the residents. The DON and ADON were to monitor incidents, events, ADLs, admissions, changes in conditions, and any resident declines. CNA E was interviewed on 1/1/26 at 1:11 p.m She stated that she worked at the facility for over 12 years and she worked the 6 a.m.- 6 p.m. shift. She stated that she was not doing hoyer lift transfers without the assistance of a second staff member. The surveyor informed her that she was named by Resident #2 to be conducting hoyer transfers by herself and she stated that the issue had been corrected, and she was in-serviced earlier that day. She stated that all hoyer transfers should be performed with at least 2 staff members. Interviews were conducted on 1/1/26 from 12:54 p.m. to 2:49 p.m. with CNA C, E, F, G, H, I, J, K, L, M, N, O, P, Q, R from the 6 a.m. -6 p.m. and the 6 p.m.- 6 a.m. shift. All staff stated that they were in-serviced on hoyer lift transfers and they completed a return demonstration on performing a hoyer transfer. All aides expressed that they were comfortable using the Hoyer lift and they were only to operate it if there were at least 2 staff members present and to have the resident centered inside the sling. They expressed that if they assumed a hoyer lift machine was defective, they should not operate it, move it from the floor, and let maintenance know as soon as possible by verbal communication and by using the QR code placed on each hall that allowed staff to place direct maintenance requests. CNAs stated that the abuse and neglect coordinator was the ADM and stated that they should alert her immediately if there were any allegations of abuse and neglect. If a CNA was to witness a fall, they were to not touch the resident and inform their charge nurse immediately, followed by the DON/ADON if the nurse was not available. The aides also explained that the Kardex was used to locate the residents' care plan and see what type of care was needed for each resident. Interviews were conducted on 1/1/26 from 1:53 p.m. to 3:56 p.m. with LVN C, D, E, F, and WCN from the 6 a.m. -6 p.m. and the 6 p.m.- 6 a.m. shift. All nurses stated that they were in-serviced on hoyer lift transfers and they completed a return demonstration on performing a Hoyer transfer. All nurses said they were comfortable using the Hoyer lift and they were only to operate it if there were at least 2 staff members present. They expressed that if they assumed a hoyer lift machine was defective, they should not operate it, move it from the floor, and let maintenance know as soon as possible by verbal communication and by using the QR code placed on each hall that allowed staff to place direct maintenance orders. The nurses stated that the abuse and neglect coordinator was the ADM and stated that they should alert her immediately if there were any allegations of abuse and neglect. If a CNA was to witness a fall, Nurses expected them to not touch the residents and inform their nurse immediately. The DON and ADON were interviewed (continued on next page)

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