STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675999	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James House of Baytown	5800 W Baker Rd Baytown, TX 77520

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse, including mental, verbal, physical, and sexual abuse, as well as abuse involving the deprivation of goods and services by staff. This deficient practice was identified for one of five residents reviewed for abuse. Specifically, Resident #1 alleged that facility staff physically held his arm down while LVN S removed his personal cell phone without his consent. This deficient practice had the potential to result in psychosocial harm, including mental and verbal abuse, as well as deprivation of services by staff. Findings included: Record review of Resident #1's face sheet, dated 3/26/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included vitamin deficiency (not having enough nutrients that your body needs), pain, hypertensive heart disease (heart problems that occur due to high blood pressure over a long), type 2 diabetes (high blood sugar level) and muscle weakness. Record review of Resident #1's quarterly MDS assessment, dated 12/25/2025, revealed a BIMS score of 12 out of 15, which indicated moderately cognitive impairment. He required assistance from staff with activities of daily living care. Record review of Resident #1's care plan initiated on 4/28/2025 revealed he has potential risk for impaired cognitive function/dementia or impaired thought processes r/t Psychotropic druguse, History of Stroke, Mild Cognitive Impairment. Interventions were to use the Resident preferred name. Identify yourself at each interaction. Face the Resident when speaking and making eye contact. Reduce any distractions- turn off TV, radio, closed door etc. The Resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. cue, reorient and supervise as needed. Record review of the facility's PIR dated 3/25/2026, revealed the alleged incident occurred on 3/18/2026, at approximately 10:45 p.m. The report indicated the facility became aware of the incident on 3/19/2026. Further review of the investigation summary revealed LVN S was given a final written warning, and re-educated on the importance of timely reporting, notifying the chain of command, and escalating resident behavioral incidents. The report further indicated CNA Z was terminated following confirmation that the CNA Z restrained resident #1's arms and refused to assist the resident out of bed upon request. Additional review of the investigation findings confirmed the allegation. Review of the post-investigation actions revealed the facility planned to continue in-servicing staff on abuse and neglect, reporting requirements (including notification of the DON and Administrator, resident rights, customer service, and documentation. During interview with Resident #1 on 3/26/2026 at 11:15 a.m., Resident #1 recalled attempting to call 911 from his room due to the noise from outside his room. The resident stated that staff took his cell phone during the incident. He reported that while the cell phone was being taken, a staff member held his hands down, preventing him from moving freely. The resident stated that he felt physically restricted during this interaction. The resident also reported that his wheelchair was removed from his room and placed outside in the hallway. He stated that he requested assistance to be transferred into his wheelchair and to leave the room; however, staff refused his request. The resident stated that he felt he was being abused. He denied any physical injury or emotional distress. During interview with Administrator on 3/26/2026 at 10:25 a.m., the (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: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 5800 W Baker Rd Baytown, TX 77520	

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administrator reported that on 03/18/2026 at approximately 10:45 p. m., Resident #1 reportedly began calling 911 multiple times (approximately 14 calls within a 10-minute period) due to perceived loud noise in the hallway, which he stated was preventing him from sleeping. Staff members (identified as LVN S and CNA Z) responded to the room. According to the resident, during the encounter, one staff member held his arms down while the other removed his cell phone from his possession (from the front of his clothing). The resident stated the cell phone was taken to the nurse's station, and he was informed it would be returned in the morning due to repeated 911 calls. The resident further reported that he requested assistance to get out of bed and into his wheelchair; however, staff declined, instructing him to remain in bed due to the late hour. The resident indicated he was unable to get up independently, as he requires a two-person assistance, and noted that his wheelchair had been removed from his room and placed in the hallway. Further investigation confirmed that CNA Z held Resident #1's arms down and was not assisting him out of bed. This action was identified as a form of physical restraint. Additionally, the removal of the resident's wheelchair and refusal to assist with mobility contributed to the restriction of the resident's movement. Although no physical injuries were observed, the actions placed the residents at risk for emotional distress and potential trauma. Corrective action was taken, including termination of the CNA Z. LVN S was given a final written warning, and re-educated on the importance of timely reporting, notifying the chain of command, and escalating resident behavioral incidents. The facility has reinforced expectations regarding abuse prevention, proper reporting procedures, and resident rights with all staff. During interview with DON on 3/26/2026 at 12:25 p.m., she stated that the incident occurred during the night shift and that she was not notified at the time. She reported that the following morning, Resident #1 informed the Administrator that his phone had been taken. According to the DON, during the Administrator's interview, Resident #1 was unable to recall that he had been calling 911 multiple times. It was later identified that the resident had called 911 approximately 14 times, prompting law enforcement to contact the facility and request staff intervention. In response, LVN S and CNA Z went to Resident #1's room, removed the phone, and placed it at the nurse's station with the intention of returning it the following day. DON stated that CNA Z was terminated after admitting to holding the resident down while the phone was being taken. LVN S was given a final written warning, and re-educated on the importance of timely reporting, notifying the chain of command, and escalating resident behavioral incidents. DON stated that holding a resident down constitutes physical restraint and is considered abuse. DON stated the potential risks of abuse on the residents, was that residents may experience physical harm, emotional distress, withdrawal, and social isolation. During interview with LVN S on 3/26/2026 at 2:25 p.m., she stated that during the incident, Resident #1 was repeatedly calling 911, and she intervened in the direction of another nurse. She took the resident's phone and planned to return it the following morning. She reported that CNA Z assisted her by holding down the resident's hand to prevent him from hitting staff. LVN S stated that she did not physically harm the resident and initially did not consider the resident to be abused. She stated that taking the resident's phone without consent constitutes abuse, and she admitted that the resident was, in fact, abused by removal of property and restraint. She indicated that the potential risks of abuse include the resident losing rights, emotional distress, and continued abuse. During interview with CNA Z on 3/26/2026 at 3:12 p.m., she reported that during her shift, the resident was exhibiting behavioral issues. While she was conducting rounds, she observed Resident #1 sitting at the edge of the bed, she assisted Resident #1 back into bed. She stated that shortly after, the resident began repeatedly calling 911. Emergency services attempted to return the calls, but the resident did not answer. She continued to monitor the situation, until LVN S later responded to the room. CNA Z stated she and LVN S removed the phone from Resident #1. She stated that the resident was attempting to hit staff, and in response, she held the resident's hands while the nurse took the phone. She affirmed that holding a resident down to prevent the resident from leaving the bed constitutes abuse, and removing a resident's personal property, such as a phone, is also considered abuse. She also stated that she was no longer (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 5800 W Baker Rd Baytown, TX 77520	

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	employed at the facility and believed her termination may be related to her involvement in the incident. She indicated that the potential risks of abuse on residents could result in psychological trauma. Record review of Employee Inservice/Training for Abuse/Neglect/Resident belongings revealed training was completed on 03/19/2026. Record review of Personnel Disciplinary Record dated 3/25/2026 for CNA Z revealed discharge due to confirmed abuse allegation. The Personnel Disciplinary Record was not signed by CNA Z with note employee refused to sign. Record review of a disciplinary form dated 3/25/2026, revealed LVN S received a final written warning. The documentation indicated that the LVN S failed to appropriately deescalate a resident's situation, inappropriately remove resident's cell phone, fail to document the incident, and failed to notify the DON/Administrator/RP regarding the incident that occurred on 3/18/2026. The LVN acknowledged and signed the disciplinary warning. Record review of facility's undated policy Abuse Prevention Investigation revealed; it is the policy of this facility to provide protection for the health, welfare and the rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident altercation. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 5800 W Baker Rd Baytown, TX 77520	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 1 of 5 residents (Resident#1) reviewed for abuse, in that: The facility failed to ensure staff followed the abuse, neglect, and exploitation policy related to reporting, investigating, and responding to allegations of abuse. This failure could place residents at risk for abuse, neglect, and exploitation.The findings included:Record review of Resident #1's face sheet, dated 3/26/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included vitamin deficiency (not having enough nutrients that your body needs), pain, hypertensive heart disease (heart problems that occur due to high blood pressure over a long), type 2 diabetes (high blood sugar level) and muscle weakness. Record review of Resident #1's quarterly MDS assessment, dated 12/25/2025, revealed a BIMS score of 12 out of 15, which indicated moderately cognitive impairment. He required assistance from staff with activities of daily living care. Record review of Resident #1's care plan initiated on 4/28/2025 revealed he has potential risk for impaired cognitive function/dementia or impaired thought processes r/t Psychotropic druguse, history of stroke, mild cognitive impairment. Interventions were to use the Resident preferred name. Identify yourself at each interaction. Face the Resident when speaking and making eye contact. Reduce any distractions- turn off TV, radio, closed door etc. The Resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. cue, reorient and supervise as needed. During interview with Administrator on 3/26/2026 at 10:25 a.m., the administrator reported that; on 03/19/2026 at approximately 11:30 a.m. to 11:45 a.m., the resident requested the return of his cell phone. At that time, facility leadership became aware of the incident, as the incident had not been previously reported by staff to the administrator. The facility leadership immediately reported the allegation to Texas Health and Human Services, and investigation was initiated. Upon completion of the investigation the facility substantiated the allegation of abuse. The cell phone was retrieved from the nurse's station and returned to the resident immediately. Upon interview, the resident denied being tied down but stated he was unable to move due to needing assistance and reported that his arms were held down during the removal of his phone. The administrator stated that staff are trained monthly on abuse, neglect, and exploitation and are required to report any incidents immediately. In this case, LVN S failed to report the incident to the administrator, stating she forgot. Further investigation confirmed that CNA Z acknowledged holding the resident's arms down and not assisting him out of bed. This action was identified as a form of physical restraint. Additionally, the removal of the resident's wheelchair and refusal to assist with mobility contributed to the restriction of the resident's movement. She stated that failure to report any suspected/witnessed abuse would delay timely investigation and interventions, which could result in continued abuse, neglect, or misappropriation of resident property. During interview with Resident #1 on 3/26/2026 at 11:15 a.m., Resident #1 reported that two staff members were involved in the incident, stating that one staff member held his hand while another staff member removed his personal cell phone without his consent. The resident stated that his cell phone was not returned to him for the remainder of the night, and he was unable to call anyone until the following day. The resident further reported that no action was taken regarding the incident until the next day, at which time he reported the situation to the administrator. The resident stated that he informed the administrator that his cell phone had been taken the previous night and had not been returned, and that no staff had communicated with him regarding its whereabouts. During interview with DON on 3/26/2026 at 12:25 p.m., she stated that the incident occurred during the night shift and that she was not notified at the time. She reported that the following morning, Resident #1 informed the Administrator that his phone had been taken. She stated that any suspected abuse should be reported immediately to the Administrator. She stated that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER St James House of Baytown		STREET ADDRESS, CITY, STATE, ZIP CODE 5800 W Baker Rd Baytown, TX 77520	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failure to report abuse could lead to continued harm to the residents, lack of timely intervention, and increased risk to other residents. During interview with LVN S on 3/26/2026 at 2:25 p.m., she stated that she took Resident #1's cell phone and planned to return it the following morning. LVN S stated that she did not physically harm the resident and initially did not consider the resident to be abused. She stated she did not notify the Administrator of the incident, as she did not initially think of it. She reported her last in-service on abuse occurred approximately 2-3 months ago, and she identified types of abuse as verbal, physical, mental, and isolation/seclusion. She stated that staff must report any suspected or witnessed abuse immediately to the Administrator, who serves as the abuse coordinator, and stated that failing to do so could result in continued resident harm and personal disciplinary consequences.During interview with CNA Z on 3/26/2026 at 3:12 p.m., she stated that the incident was not reported to the Administrator and she was unsure why it was not reported, noting that the nurse in charge was responsible for reporting. She stated that failure to report abuse could result in the incident continuing and could cause further harm to the residents. Record review of facility's undated policy Abuse Prevention and Investigation revealed; The facility will have written procedures that include: 1. Reporting of all alleged violations to the administrator, state agency, Adult Protective Services and to all other required agencies within specified timeframes: a. immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675999	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James House of Baytown	5800 W Baker Rd Baytown, TX 77520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving were reported immediately, but not later than 24 hours, to the administrator of the facility for 1 of 5 resident (Resident #1) reviewed for reporting. Resident #1 alleged that facility staff physically held his arm down while LVN S removed his personal cell phone without his consent, and this allegation was not reported to the administrator at the time it occurred. This failure had the potential to delay timely investigation and implementation of protective interventions, which could result in continued abuse, neglect, or misappropriation of resident property.Findings included: Record review of Resident #1's face sheet, dated 3/26/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included vitamin deficiency (not having enough nutrients that your body needs), pain, hypertensive heart disease (heart problems that occur due to high blood pressure over a long), type 2 diabetes (high blood sugar level) and muscle weakness.Record review of Resident #1's quarterly MDS assessment, dated 12/25/2025, revealed a BIMS score of 12 out of 15, which indicated moderately cognitive impairment. He required assistance from staff with activities of daily living care. Record review of Resident #1's care plan initiated on 4/28/2025 revealed he has potential risk for impaired cognitive function/dementia or impaired thought processes r/t Psychotropic druguse, history of stroke, mild cognitive impairment. Interventions were to use the Resident preferred name. Identify yourself at each interaction. Face the Resident when speaking and making eye contact. Reduce any distractions- turn off TV, radio, closed door etc. The Resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. cue, reorient and supervise as needed. During interview with Administrator on 3/26/2026 at 10:25 a.m., the administrator reported that; on 03/19/2026 at approximately 11:30 a.m. to 11:45 a.m., the resident requested the return of his cell phone. At that time, facility leadership became aware of the incident, as the incident had not been previously reported by staff to the administrator. The facility leadership immediately reported the allegation to Texas Health and Human Services, and investigation was initiated. Upon completion of the investigation the facility substantiated the allegation of abuse. The cell phone was retrieved from the nurse's station and returned to the resident immediately. Upon interview, the resident denied being tied down but stated he was unable to move due to needing assistance and reported that his arms were held down during the removal of his phone. The administrator stated that staff are trained monthly on abuse, neglect, and exploitation and are required to report any incidents immediately. In this case, LVN S failed to report the incident to the administrator, stating she forgot. Further investigation confirmed that CNA Z acknowledged holding the resident's arms down and not assisting him out of bed. This action was identified as a form of physical restraint. Additionally, the removal of the resident's wheelchair and refusal to assist with mobility contributed to the restriction of the resident's movement. She stated that failure to report any suspected/witnessed abuse would delay timely investigation and interventions, which could result in continued abuse, neglect, or misappropriation of resident property. During interview with Resident #1 on 3/26/2026 at 11:15 a.m., Resident #1 reported that two staff members were involved in the incident, stating that one staff member held his hand while another staff member removed his personal cell phone without his consent. The resident stated that his cell phone was not returned to him for the remainder of the night, and he was unable to call anyone until the following day. The resident further reported that no action was taken regarding the incident until the next day, at which time he reported the situation to the administrator. The resident stated that he informed the administrator that his cell phone had been taken the previous night and had not been returned, and that no staff had communicated with him regarding its whereabouts. During interview with DON on 3/26/2026 at 12:25 p.m., she stated that the incident occurred during the night shift and that she was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James House of Baytown	5800 W Baker Rd Baytown, TX 77520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not notified at the time. She reported that the following morning, Resident #1 informed the Administrator that his phone had been taken. She stated that any suspected abuse should be reported immediately to the Administrator. She stated that failure to report abuse could lead to continued harm to the residents, lack of timely intervention, and increased risk to other residents. During interview with LVN S on 3/26/2026 at 2:25 p.m., she stated that she took Resident #1's cell phone and planned to return it the following morning. LVN S stated that she did not physically harm the resident and initially did not consider the resident to be abused. She stated she did not notify the Administrator of the incident, as she did not initially think of it. She reported her last in-service on abuse occurred approximately 2-3 months ago, and she identified types of abuse as verbal, physical, mental, and isolation/seclusion. She stated that staff must report any suspected or witnessed abuse immediately to the Administrator, who serves as the abuse coordinator, and stated that failing to do so could result in continued resident harm and personal disciplinary consequences.During interview with CNA Z on 3/26/2026 at 3:12 p.m., she stated that the incident was not reported to the Administrator and she was unsure why it was not reported, noting that the nurse in charge was responsible for reporting. She stated that failure to report abuse could result in the incident continuing and could cause further harm to the residents. Record review of facility's undated policy Abuse Prevention and Investigation revealed; The facility will have written procedures that include: 1. Reporting of all alleged violations to the administrator, state agency, Adult Protective Services and to all other required agencies within specified timeframes: a. immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.