STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676223	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayou Pines Care Center	4905 Fleming Street LA Marque, TX 77568

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 1 (Resident #1) of 11 residents reviewed for ADLs. The facility failed to provide timely incontinent care for Resident #1. This failure can place residents at risk for embarrassment, rashes, infections, discomfort, and skin breakdown. Findings included: Record review of face sheet dated 08/04/2022 indicated Resident #1 was a [AGE] year-old female who was admitted on [DATE] and who was readmitted on [DATE]. Resident #1 diagnoses included dementia, muscle weakness, delirium cerebral infarctions , heart failure, A-Fib, depression, Poly osteoarthritis, viral hepatitis c, insomnia, history of UTI, and anxiety disorder. Record review of a Quarterly MDS dated [DATE] indicated Resident #1 had a BIMS of 99 indicating severely cognitively impaired. Record review of a care plan dated 08/19/2022, indicated Resident #1 had a communication problem r/t Expressive Aphasia. Date Initiated: 08/17/2022, OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or use of sign language as alternate communication to speech. Date Initiated: 08/17/2022, Revision on: 03/17/2025 OT PT. Review factors affecting underlying cause of communication deficit, recent onset, chronic or recurrent conditions, success of attempted remedial actions, ability to compensate with nonverbal strategies, understanding in particular situations etc. Date Initiated: 08/17/2022, Revision on: 03/17/2025. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review continued of care plan dated 08/19/2022, indicated Resident #1 had an ADL Self Care Performance Deficits poor cognition and decreased independent mobility with muscle weakness and lack of coordination. Date Initiated: 04/05/2022. Resident #1 will improve current level of function in bed mobility, transfers, dressing, toilet use and personal hygiene by the next review date. Date Initiated: 04/05/2022, Target Date: 06/02/2025. TRANSFER: Resident #1, is now a gait belt transfer with 1 person assist. Date Initiated: 04/05/2022, Revision on: 03/17/2025, CNA/Nursing staff will assist with, bathing: Resident #1 requires) (X1) staff participation with bathing. Date Initiated: 04/05/2022, Revision on: 03/17/2025 CNA, TOILET USE: Resident #1 requires) (X1) staff participation to use toilet. Date Initiated: 04/05/2022, Revision on: 03/17/2025. Change clothing after incontinence episodes. CNA/ Nursing staff will assist with bed mobility: Resident #1 requires (X1) staff participation to reposition and turn in bed. Date Initiated: 04/05/2022, Revision on: 03/17/2025 CNA/Nursing staff will assist with, personal hygiene and oral care Resident #1 requires (X1) staff participation with personal hygiene and oral care. Date Initiated: 04/05/2022, Revision on: 03/17/2025 CNA/Nursing staff will provide dressing: Resident #1 requires (X1) staff participation to dress. Date Initiated: 04/05/2022 Revision on: 03/17/2025, EATING: Resident #1 requires (x1) staff participation to eat. Date Initiated: 04/05/2022, Revision on: 03/17/2025. Resident #1 was at risk of pressure ulcers r/t incontinent episodes and impaired independent mobility at times. Date Initiated: 04/05/2022. Interview with Resident #1 family member on 06/11/2025 at 10:30 a.m., she stated the facility did not provide Resident #1 with incontinent care for more than 4 hours on 5/10/2025. Resident #1 was incontinent of urine and bowel which required assistance with ADLs and had a rash on her buttocks and inner and back of thighs. Resident #1's brief and sheets were saturated with urine and feces. Resident #1's brief was soaked with feces that was in the vaginal area and between Resident #1's inner thighs. Resident #1's mattress sheets was soaked with urine and feces. The FM of Resident #1 was not provided showers as scheduled. FM said Resident #1 did not receive a bath or changing of briefs until family member arrived later that day. Interview on 06/11/2025 at 11:00 a.m. CNA A said we are to check on residents every two hour or more frequently if needed for incontinent episodes. She said she came in on her shift at 7:30 am and found Resident #1's brief was soaked and soiled, she said she changed her but her family member walked in while she was changing her so she saw all the stuff on Resident #1. She said she would notify charge nurse of Resident #1 having diarrhea and had some redness on her buttocks. She said this could lead to neglect and considered abuse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/2025 at 11:30 a.m. CNA B said she heard about the incident with Resident #1 and her family member was talking to the nurse and said she asked for Resident #1 to be changed more often because she was having diarrhea, and she was found with a soiled dress and her wheelchair had bowel in it also. She said she heard the charge nurse tell the aide Just go clean her up. She said not being able to provide resident with assistance could be considered neglect and abuse because they are not clean. Interview on 06/11/2025 at 12:35 p.m. Charge Nurse A, said she did not know Resident #1 was in bed with soiled brief, and linen. She assigned the bath schedule and could not see where Resident #1 had been bathed and staff are supposed to make rounds and change incontinent residents at least every two hours. If residents are not changed that could put them at risk for embarrassment, possible isolation and withdraw from their peers. Interview on 06/11/2025 at 1:00p.m. the DON said, she was made aware of the incident with Resident #1. DON said the daughter of Resident #1 showed me the picture of the soiled diapers and the gown that was soiled. She said she I apologized and provided in-services to all staff. She said since then to her knowledge, we have not had any more issues. She said not changing our residents could be considered neglect. Record review of the facility policy and procedure for Perineal care dated 08/19/2022 revealed The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review the facility failed to have sufficient nursing staff with the appropriate skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for residents. The facility failed to have sufficient staff on each of the four halls. Based on observation on 6/10/2025 at 8:45 a.m. Hall 100 had 1 CNA and 1 Nurse, Hall 200 had 1 CNA, Hall 300 had 2 CAN's and Hall 400 there were no CNA during rounds. This failure could place resident at risk of decrease quality of life and quality of care. During an interview on 6/11/2025 at 10:00a.m. Resident #1's family member stated, I don't think they have enough staff at night, they have a lot of call ins, and the residents are suffering because of it. She said she noticed that a lot of the staff that was here for a long time just quit after the new company took over. She said she come in the evening, and found Resident #1 in a dirty brief, and had to walk around to find someone to help. She said she just end up doing the incontinent care herself, it was never like this before. She said they say they are making changes, but I don't see it. I see 1 nurse and maybe 2 CNAs in the evening Interview with Resident #2, on 6/11/2025 at 10:45 a.m., said, at night he only see one person on his hall and when he wonders around, he only see 3 people in the building at night, that is a nurse and aids. He said he can do things for himself but his wife could not so he would press the call light and it would take them at least an hour to get to her. He said this type of stuff made him upset. Interview with Resident #3, on 6/11/2025 at 11:00a.m., she said she has had to wait for a while to get assistance to the bathroom or to get her roommate help at night, she said the daytime is so so. She said she a lot of patience but we just need the help if we can get it. A confidential interview, revealed they often work shorthanded at nights; this seems to be an ongoing thing staff having stay over sometimes because the person did not come in or was running late. A lot of the residents need assistance with their ADL's. A lot of people quit because of the pay and the new company and the Administrator. We have asked for help, but the DON said they just don't have the staff. They are supposed to come in, but they don't. If the staff don't come in this could lead to our residents not getting the care they need. A confidential interview, revealed they been working short staffed for a while, and it is not getting any better, they offered an incentive, but no one takes it because you may be the only one here that day. Interview with DON on 6/11/2025 at 1:30 p.m., said they have had a lot of call ins on 7p to 7a shift. They have offered sign on bonus and incentives. If we have call ins we try to fill the spot. We have had times where we were not able to fill the spot. If it's not enough staff, it can place the residents in harm, and they would not get the care they deserve. We have an on-call shifts now and a new ADON that will assist with filling in as needed the wound care nurse will assist as well. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with HR on 6/11/2025 at 1:45p.m., said they do not make the staffing schedule the DON does. HR said they process the applications and payroll. Interview with the ADON on 6/11/2025 at 2:00p.m., said they just started this is their first week, and is, aware of the on call but have not done it. The ADON said they are aware of staffing issues on the night shift and we are trying to fix it. The ADON said if it is not enough staff, it can jeopardize the care of the residents. Interview with the Administrator on 6/11/2025 at 2:30p.m., said they was told about staffing issues with the shifts, and we are working on trying to hire people. Observation on 6/10/2025 at 8:30p.m., the facility had 1 LVN and 2 CNAs. Staffing scheduled noted 1 RN, 2 LVNs and 5 CNA's for 7a to 7p shift. Observation on 6/11/2025 at 9:00a.m, the DON posted at door staffing 7a 7p 1 RN, 3, LVNs, 2 CMAs, 7 CNAs and 7p-7a shift was 1 RN, 2 LVNs, 5 CNAs. Observations made on the floor was as follows 0 RNs outside of the DON, 2 LVNs and each hall was 1 CNA (4halls in total). Restorative aide was assigned to help each hall. 1 CMA was passing medication on each hall. A confidential interview revealed at nights sometimes there was only 1 CNA for the entire building. No one person or 2 can provide the care these residents need with just 2 or 3 people at night . All of this can place the resident at risk for being neglected. A confidential interview revealed its just not enough people even in the daytime, it is short staffed and the management nurse just walks around. Interview with Administrator on 6/11/2025 at 2:00p.m., requested policy on staffing. Administrator stated there is no policy staffing as of now. The company is implementing new policy and procedures.