

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2025
NAME OF PROVIDER OR SUPPLIER Bayou Pines Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 5 residents (Resident #9) reviewed for ADL care. The facility failed to provide Resident #9 assistance with timely incontinence care for at least 4 hours for the following time 7:30PM on day 6/12/2025. Resident #9 was incontinent of urine, required assistance with ADL's, and had redness to her buttocks. Resident #9's brief and sheets were saturated with urine and urine soaked through to her mattress. Resident #9 was provided continent care 6 hours later. The facility did not provide Resident #9 with incontinent care for 10 hours and Resident #9 wore soiled brief 10 hours. This failure could place the residents who are dependent on staff for toileting at risk for self worth, embarrassment, rash, skin breakdown, and infection. Findings Include: Record review on 7/29/2025 at 9:30 AM revealed Resident #9 is an [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of acute on chronic systolic congestive heart failure (heart's lower left chambers cannot pump enough blood out to the body) major depressive disorder, recurrent, unspecified. Record review of Resident #9's admission MDS dated [DATE] revealed she had a BIMS score of 13 out of 15 indicating she was cognitively intact. Record Review on 7/29/2025 at 9:45 AM of Resident #9 progress notes and Kardex revealed Resident #9 had a change of condition on 6/17/2025; notes stated Resident #9 required assistance with transfers, limited mobility and assistance with ADL care. Resident #9's change of condition MDS date 6/24/2025 section GG area C noted Resident #9 as being dependent in toileting hygiene. Observation on 7/29/2025 at 11:00 AM. On 7/31/2025 at 9:25PM CNA A1 entered Resident#9's room, proceeded ask Resident #9 how she was doing and informed Resident #9 that she will return at 10:30PM to put her to bed. Resident #9 stated she wanted to sleep in her recliner. CNA A proceed to tell Resident #9 you know you cannot sleep in your chair, I have to put you in the bed so I can change you it is easy for me that way. Observation on 7/29/2025 at 12:00PM of picture presented by RP of Resident #9's revealed bed sheets were soiled with ring under Resident #9's brief, bed linen was on the floor. Interview with MDS nurse on 7/30/2025 at 2:00PM she stated Resident #9 when Resident #9 was admitted she was able to walk and then she got sick and went to hospital back in June and had a decline and a change of condition was done where she was changed to dependent for toileting and other ADL care. Telephone Interview with CNA B on 7/30/2025 at 3:34PM stated when she came on shift on 6/13/2025 at 7:10AM she found Resident #9 lying in bed with soiled bed sheets and Resident #9's brief was soaked. CNA B stated this failure could make Residents feel nasty, dirty and possibly sad. Interview with Resident #9's RP on 7/31/2025 at 11:30AM. She stated that on 7/30/2025 at 7:36PM she received an alert from Resident #9's camera which was a recording of CNA A introducing herself and asking Resident #9 how she was doing and if she needed anything. CNA A was seen going to dresser drawer to sign in sheet. Resident #9 is heard saying I would like to go to the bathroom. CNA A proceeds to tell Resident #9 you have a brief on you remember. Resident #9 RP stated she zoomed the camera in and she could see that Resident #9 had a wet ring on her on the sheets. Interview with facility DON on 7/31/2025 at 1:00PM she stated she was made aware of incident and saw video. The DON stated she called CNA A to discuss concern wrote CNA A up, and terminated CNA A due to several customer service complaints and employee was within her 90-day probation period. The DON stated this failure could make residents feel like they were neglected and sad from the lack of care provided. I have implemented a sign in out sheet for all nursing staff to note their daily task for this resident. Interview with facility Administrator on 7/31/2025 at 1:30PM he stated he was made aware of situation and was told by DON that CNA A was terminated due to multiple incidents. The Administrator stated this failure could result in overall poor care. Record review of facility policy and procedure for ADL care dated March 2018 stated the following: Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with bathing.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop baseline care plans that included instructions to provide effective and person-centered care needs for 2 (CR #94, Resident #17) of 24 residents reviewed for baseline care plans. Baseline care plans were not developed for Resident # 17 and CR #94. These failures placed newly admitted residents at risk of not having their care needs addressed. Resident # 17 Record review of Resident #17s face sheet revealed admission date 6/10/25 with diagnoses including hypertension (high blood pressure), osteoarthritis (degenerative bone disease), acute kidney failure (inability of kidneys to filter blood), renal dialysis (artificial means of removing waste and excess fluid from the blood), transient cerebral ischemic attack (brief stroke-like attack), heart failure (inability of heart to pump blood efficiently), dementia (loss of cognitive functioning), and depression (persistent sadness, loss of interest, difficulty functioning in daily life). Record review of Resident #17s admission MDS dated [DATE] revealed BIMS 02, indicating severely impaired cognitive skills, moderate hearing difficulty, Dialysis, 02 therapy, OT started 6/11/25, PT started 6/14/25, and dependence on staff for all ADLs. Record review of completed assessments for Resident # 17 revealed no evidence of development of a baseline care plan. Interview with MDS nurse on 7/30/25 at 2pm revealed the floor nurse does the baseline care plan, from observations and interviews of residents, and the MDS does the comprehensive care plan. She said she did not know why the baseline care plan was not completed for Resident #17. She said the risk of not having a baseline care plan would be the resident would not receive adequate care. Interview with Corporate MDS on 7/30/25 at 2:30pm, he said the baseline care plan should be completed within 72 hours of admission to the facility, then it goes to MDS for the comprehensive care plan. He said he did not know why the baseline care plan for Resident # 17 was not done timely. Interview with the DON on 7/30/25 at 3pm revealed the baseline care plan should be created at least 48 hours after a resident's admission. She said if the baseline care plan was not done, the staff would not be informed of a resident's needs, and the resident would not receive proper care. CR #94 Record review of CR #94's face sheet dated 7/30/2025, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Rhabdomyolysis (muscles break down and release toxins into your blood and kidneys). CR #94's discharge revealed 7/14/2025 at 0850. Record review of CR #94's MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of an 8 mean moderate cognitive impairment (the individual may require additional support and monitoring for cognitive function). During interview on 7/30/2025 at 12:40 pm, the MDS Coordinator A said MDS is responsible for initiating and developing the comprehensive care plan to ensure the residents continuity of care. The MDS Coordinator A said she was responsible for all the care plans both baseline and comprehensive. The MDS Coordinator A said if the care plans are not complete or inaccurate it could impact the residents by nursing direct care staff missing out providing care to the residents. During interview on 7/31/2025 at 9:00 am, the DON said CR #94 look like someone tried to start the baseline care plan but when you open it nothing is in it. Record review of the facility policy Care Plans - Baseline, dated December 2016 revealed, in part to assure the resident's immediate needs are met and maintained, a baseline care plan will be developed within 48 hours of admission.the baseline care plan will be used until staff can conduct a comprehensive assessment and develop an interdisciplinary person-centered care plan.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**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 comprehensive person-centered care plan for each resident, that includes measurable objective and time frames to meet resident's medical, nursing, mental and psychosocial needs for 3 (CR #94, Resident #17, Resident#10) of 24 residents reviewed for care plans. The facility failed to develop and implement CR #94, Resident #17, Resident #10's care plans in a manner that ensured person-centered care, with appropriate interventions aligned to meet the resident's identified goals and needs. The Facility failed to ensure Resident #10's indwelling urinary catheter was care planned. The facility failed to ensure Resident #10's Stage 4 sacral wound was care planned. The facility failed to ensure Resident #10's IV antibiotic was care planned. These failures could place residents at risk of not receiving care and services tailored to their identified needs, potentially preventing them from maintaining their highest physical, mental and psychosocial well-being. Findings included: CR #94 Record review of CR #94's face sheet dated 7/30/2025, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Rhabdomyolysis (muscles break down and release toxins into your blood and kidneys). CR #94's discharge was revealed as 7/14/2025 at 0850. Record review of CR #94's MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of an 8 meaning moderate cognitive impairment (the individual may require additional support and monitoring for cognitive function). Continued record review revealed in Section V care assessment area (CAA) cognitive loss/dementia dated 6/26/2025, ADL Functional/Rehabilitation potential dated 6/26/2025, Urinary Incontinence and Indwelling Catheter dated 6/26/2025, Falls dated 6/26/2025, pressure Ulcer 6/26/2025. During interview on 7/30/2025 at 12:40 pm, the MDS Coordinator A said MDS is responsible for initiating and developing the comprehensive care plan to ensure the residents continuity of care. MDS Coordinator A said she was responsible for all the care plans both baseline and comprehensive. MDS Coordinator A said if the care plans are not complete or inaccurate it could impact the residents by nursing direct care staff missing out providing care to the residents. Record review of CR #94's care plan printed and saved dated 7/31/2025 once opened revealed an empty screen. During interview on 7/31/2025 at 9:00 am, the DON said CR #94 does not have a care plan. Resident #17 Record review of Resident #17's face sheet revealed admission date 6/10/25 with diagnoses including hypertension (high blood pressure), osteoarthritis (degenerative bone disease), acute kidney failure (inability of kidneys to filter blood), renal dialysis (artificial means of removing waste and excess fluid from the blood), transient cerebral ischemic attack (brief stroke-like attack), heart failure (inability of heart to pump blood efficiently), dementia (loss of cognitive functioning), and depression (persistent sadness, loss of interest, difficulty functioning in daily life). Record review of Resident #17's admission MDS dated [DATE] revealed BIMS 02, indicating severely impaired cognitive skills, moderate hearing difficulty, Dialysis, 02 therapy, OT started 6/11/25, PT started 6/14/25, and dependence on staff for ADLs including bathing, dressing, hygiene, toileting Record review of Resident # 17's completed comprehensive care plans revealed there was no evidence of development of a comprehensive care plan, with goals or interventions for ADL's. Resident #10 Record review of Resident #10's admission Record revealed she was a [AGE] year old female who admitted to the facility on [DATE] with a diagnosis of lymphedema (a condition of swelling usually in an arm or leg that is caused by a lymphatic system blockage), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar), hoarding disorder (a persistent difficulty in discarding or paring with possessions because of a perceived need to keep them), personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms), essential hypertension (high blood pressure), and pressure ulcer of sacral region, stage 4 (a wound caused by constant skin contact with a surface, related to prolonged pressure and tissue damage with full thickness tissue loss with exposed bone, tendon, or muscle). Record review of Resident #10's admission MDS dated [DATE] revealed she had a BIMS score of 15 out of 15 indicating her cognition was intact. Continued record review revealed she was coded in section H-Bladder and Bowel, as A. Indwelling catheter (including suprapubic catheter and nephrostomy tube), and in Section M-Skin Conditions- as D. Stage 4: Full thickness tissue loss, with exposed bone, tendon, or muscle.1. Number of stage 4 pressure ulcers and was coded with the number 1. Section V-Care Area Assessment (CAA) Summary revealed in part: 1. Check column A if care area is triggered. 2 For each triggered Care Area, indicate whether a new care plan, care plan revision, for</p>		

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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. (continued on next page)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 5 residents (Resident #9) reviewed for ADL care. The facility failed to provide Resident #9 assistance with timely incontinence care for at least 4 hours for the following time 7:30PM on day 6/12/2025. Resident #9 was incontinent of urine, required assistance with ADL's, and had redness to her buttocks. Resident #9's brief and sheets were saturated with urine and urine soaked through to her mattress. Resident #9 was provided continent care 6 hours later. The facility did not provide Resident #9 with incontinent care for 10 hours and Resident #9 wore soiled brief 10 hours. This failure could place the residents who are dependent on staff for toileting at risk for self worth, embarrassment, rash, skin breakdown, and infection. Findings Include: Record review on 7/29/2025 at 9:30 AM revealed Resident #9 is an [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of acute on chronic systolic congestive heart failure (heart's lower left chambers cannot pump enough blood out to the body) major depressive disorder, recurrent, unspecified. Record review of Resident #9's admission MDS dated [DATE] revealed she had a BIMS score of 13 out of 15 indicating she was cognitively intact. Record Review on 7/29/2025 at 9:45 AM of Resident #9 progress notes and Kardex revealed Resident #9 had a change of condition on 6/17/2025; notes stated Resident #9 required assistance with transfers, limited mobility and assistance with ADL care. Resident #9's change of condition MDS date 6/24/2025 section GG area C noted Resident #9 as being dependent in toileting hygiene. Observation on 7/29/2025 at 11:00 AM. On 7/31/2025 at 9:25PM CNA A1 entered Resident#9's room, proceeded ask Resident #9 how she was doing and informed Resident #9 that she will return at 10:30PM to put her to bed. Resident #9 stated she wanted to sleep in her recliner. CNA A proceed to tell Resident #9 you know you cannot sleep in your chair, I have to put you in the bed so I can change you it is easy for me that way. Observation on 7/29/2025 at 12:00PM of picture presented by RP of Resident #9's revealed bed sheets were soiled with ring under Resident #9's brief, bed linen was on the floor. Interview with MDS nurse on 7/30/2025 at 2:00PM she stated Resident #9 when Resident #9 was admitted she was able to walk and then she got sick and went to hospital back in June and had a decline and a change of condition was done where she was changed to dependent for toileting and other ADL care. Telephone Interview with CNA B on 7/30/2025 at 3:34PM stated when she came on shift on 6/13/2025 at 7:10AM she found Resident #9 lying in bed with soiled bed sheets and Resident #9's brief was soaked. CNA B stated this failure could make Residents feel nasty, dirty and possibly sad. Interview with Resident #9's RP on 7/31/2025 at 11:30AM. She stated that on 7/30/2025 at 7:36PM she received an alert from Resident #9's camera which was a recording of CNA A introducing herself and asking Resident #9 how she was doing and if she needed anything. CNA A was seen going to dresser drawer to sign in sheet. Resident #9 is heard saying I would like to go to the bathroom. CNA A proceeds to tell Resident #9 you have a brief on you remember. Resident #9 RP stated she zoomed the camera in and she could see that Resident #9 had a wet ring on her on the sheets. Interview with facility DON on 7/31/2025 at 1:00PM she stated she was made aware of incident and saw video. The DON stated she called CNA A to discuss concern wrote CNA A up, and terminated CNA A due to several customer service complaints and employee was within her 90-day probation period. The DON stated this failure could make residents feel like they were neglected and sad from the lack of care provided. I have implemented a sign in out sheet for all nursing staff to note their daily task for this resident. Interview with facility Administrator on 7/31/2025 at 1:30PM he stated he was made aware of situation and was told by DON that CNA A was terminated due to multiple incidents. The Administrator stated this failure could result in overall poor care. Record review of facility policy and procedure for ADL care dated March 2018 stated the following: Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with bathing.</p>		