STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676282	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayou Manor	4141 S Braeswood Blvd Houston, TX 77025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for the residents, consistent with residents' rights, that include measurable objectives and timeframes to meet the residents' medical, nursing, mental and psychological needs, for 1 (Resident # 1) of 6 residents reviewed for comprehensive person-centered care plan. The MDS Coordinator failed to develop a comprehensive person-centered care plan for Resident # 1 within the timeframe and measurable objective for Resident # 1 who was a fall risk and had actual falls on 05/17/2026 and 05/18/2026. This failure could place residents at risk for recurrent falls by not having their needs met.Findings included: Record review of Resident # 1's face sheet dated 04/23/2026 revealed she was an [AGE] year-old female with the following diagnoses: Generalized muscle weakness, unsteady on feet and other lack of coordination (A loss of overall physical power, often linked to fatigue, nerve damage from inactivity). Record review of Resident # 1's MDS dated [DATE] revealed she had a BIMS score of 09 (moderate problem with thinking and memory). The MDS section J1700 revealed Resident # 1 was admitted with a history of fall on admission. Record review of Resident # 1's care plan dated 5/19/2026 that was updated after surveyor's intervention revealed: -The resident is high risk for falls, related to weakness and unsteady gait. Goal: The resident will not sustain serious injury. Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage resident to use the call light for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/ family/caregivers about safety and what to do is a fall occurs. Ensure the resident is wearing appropriate footwear non-skid soaks when ambulating or mobilizing in wheelchair. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter, remove any potential causes if possible. Educate resident/ family/caregivers/IDT as to cause.-The resident has bladder incontinence related to confusion, impaired mobility. Goal: The resident will remain free of skin breakdown. Interventions: Ensure the resident has unobstructed path to the bathroom.-The resident has had an actual fall on 05/17/2026 and 05/18/2028 with no injury due to poor balance, unsteady gait and confusion. Goal: The resident will resume usual activities without further accidents. Intervention: Determine and address causative factors of the fall. Monitor/document/ report PRN X 72 to MD for S/S of: pain, bruise, change in mental status, new onset of confusion, sleepiness, inability to maintain posture and agitation. Check BP lying/ sitting and standing X 1 in the first 24 hours. Record review of Resident # 1's hospital records dated 04/23/2026 revealed, impaired upper extremity strength, impaired endurance (physical capacity to sustain prolonged activity) impaired functional mobility, impaired trunk control. Patient presents as high fall risk. Record review of Resident # 1's clinical records dated 4/24/2026 revealed, she was admitted to the facility with a primary diagnosis of fall with AMS (altered mental status) and dehydration. In an interview with the MDS Coordinator on 05/19/2026 at 2:21 p.m., she said Resident # 1 had no comprehensive person-centered care plan because she had not completed one. She said it was her responsibility to complete care plans when residents are admitted into the facility. The MDS Coordinator said, the fact (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident # 1 did not have a comprehensive person-centered care plan completed in a timely manner was that the nurses and CNAs would not have proper guidance that was needed to provide quality care to Resident # 1. She said the delay in competing a comprehensive person-centered care plan might lead to delayed care. In an interview with LVN A on 05/19/2026 at 2:35 p.m., she said she would normally refer to a care plan to know what care to provide to a resident. She said if there was no comprehensive person-centered care plan, the residents would not get the required care specifically for them. LVN A said her priority was safety for the residents, thus she needed a comprehensive person-centered care plan for directions. In an interview with LVN B on 05/19/2026 at 3:14 pm, she said, it was the responsibility of the MDS Coordinator to complete a Comprehensive person-centered care plan. She said if the comprehensive person-centered care plan was not completed in a timely manner for Resident # 1, staff would not know how to care for Resident # 1. She said Resident # 1 would not have had the proper care she deserved. In an interview with the DON on 05/19/2026 at 4:15 p.m., she said the baseline care plan was initiated within the first 21 days of admission. The baseline care plan revealed Resident # 1 had a history of fall. She said it was the responsibility of the MDS Coordinator to develop the comprehensive person-centered care plan. The DON said, if the comprehensive person-centered care plan was not developed for Resident # 1, specific triggered incidents such as falls would not be notified by the staff. She said in the absence of a comprehensive person-centered care plan for Resident # 1, the care would not have been individualized which would have resulted to staff missing pertinent care areas. In an interview with the ADM on 05/19/2026 at 4:44 p.m., he said a care plan was designed to make sure all parties involved in the care of a resident were on the same page with the care of the resident. The ADM said if a care plan was not completed in a timely manner, the risk was that staff would not understand everything about the residents. Record review of facility's Care Plan, Comprehensive Person-Centered revised on March 2022 revealed the following: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident physical, psychological and functional needs is developed and implemented for each resident. -The comprehensive person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant change in status), and no more than 21 days after admission. -Includes the resident's stated goals upon admission and desired outcomes.-Reflects currently recognized standards of practice for problem areas and conditions.-Interventions address the underlying source (s) of the problem area(s), not just symptoms or triggers.