STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676332	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Bay Area	4900 East Sam Houston Parkway South Pasadena, TX 77505

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on observation and interview, the facility failed to ensure each resident had a right to be free from abuse and neglect for 2 (Resident #1 and Resident #2) of six residents reviewed for abuse and neglect. -The DON caused emotional abuse to Resident #1 who was diagnosed with bipolar disorder and still had menstrual cycles when she cursed at Resident #1 and stated she could not have any more than 8 adult briefs for 2 days. -The DON caused emotional abuse to Resident #2 when she stated that Resident #2 got on her nerves when she used her call light multiple times. Findings included: Record review of Resident#1's face sheet dated 3/8/24 revealed she was admitted on [DATE] with diagnoses of bipolar disorder (extreme mood swings), multiple sclerosis (immune system attacking the brain and spinal cord-central nervous system), insomnia (cannot sleep), anemia, obesity, lymphedema (swelling due to build up of lymph fluid), and mood disorder with depressive features. Record review of Resident #1's MDS assessment dated [DATE] revealed a BIMS Summary Score of 15 indicating her cognition was intact. The functional limitation in range of motion revealed impairment on both sides of lower extremity. She required substantial/maximal assistance for toileting hygiene, personal hygiene, and she required partial/moderate assistance for lower body dressing. Toilet transfer was not attempted due to medical condition or safety concerns. She was always incontinent of urine and bowel and was at risk of pressure ulcers/injuries. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's undated care plan dated 10/18/23 revealed resident had bladder/bowel incontinence r/t impaired mobility and MS. Interventions were Clean peri-area with each incontinence episode, incontinent: check the resident every 2 hours and as required for incontinence care and PRN . Resident #1 has Multiple sclerosis and interventions/tasks were Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments .Monitor/document/report to MD PRN: S/SX of damage to motor and sensory control centers: urinary frequency, urgency or retention, urinary or fecal incontinence, constipation. She has an ADL Self Care performance deficit r/t MS, limited mobility with interventions to praise all efforts at self-care, transfer: the resident requires extensive assist x 1 staff participation to reposition and turn in bed, encourage the resident to participate to the fullest extent possible with each interaction .personal hygiene/oral care: the resident requires extensive assist x1 staff participation with personal hygiene and oral care. In an interview on 03/8/24 at 11 a.m., Resident #1 stated that she was out of diapers, and she drinks 6 or 7oz cups of water a day. She stated that on the daily, she urinated a lot and the DON passed diapers on Tuesday and Thursday. Resident #1 stated the CNA had to get diapers from another resident's room so that she could be changed. Resident #1 stated the size 3X diapers came with 8 in a pack. She stated the DON kept the diapers locked up in her room and if the DON was gone, Resident #1 needed diapers. Resident #1 stated the DON was not allowed in her room anymore because they had gone back and forth in conversation regarding the diapers (unknown date). She explained that the DON said I ain't giving you shit, you got diapers and I knew I should not have went in there (Resident#1's room) wasting my got damn time. Resident #1 described the DON as raw and stated the staff were scared and did not want to say anything. Resident #1 stated the DON made her feel bad and the DON should not talk down on anyone. She expressed that she had bipolar disorder, and it got her frustrated where she called her family member hollering, screaming, and crying because the DON had thrown her into a [NAME]. Resident #1 stated the 3X diapers came with 8 to a pack. She stated the DON kept the diapers locked up in her room and when the DON was gone Resident #1 needed diapers. In an interview on 03/8/24 at 11:40 a.m., CNA A described the DON's communication style as someone who would talk to her crazy. She stated she saw the DON leave Resident #1's room and talk badly about Resident #1 after the DON told Resident #1 about the number of diapers she was given and the DON stated that was all Resident #1 was getting. CNA A stated on 02/23/24 while she was in the room with Resident #1 and the DON, while Resident #1 was talking to the DON, the DON walked out during the middle of her conversation and continued doing what she was doing. CNA A stated that CNAs did not have access to supplies, did not get trash bags anymore, and had to use what supplies the DON put in the rooms. CNA A also stated that she worked Friday, Saturday, and Sunday when Resident #1 was short on diapers. She explained that Resident #1 received 2 packs of diapers on Fridays with only 8 diapers in them (16 total) until Monday. She explained when Resident #1 had her menstrual cycle, she would go through a whole pack on her 12-hour shift. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 3/8/24 at 12:10 p.m. with CNA B she stated she has heard the DON say to Resident #1, who still had a menstrual cycle and she needed diapers to tell the family to bring Resident #1 pads because she was on her cycle and that was not her business. CNA B stated the DON limits Resident #1's diapers. CNA B stated she asked the DON for more diapers for Resident #1 and the DON told her that she could not bring more diapers to Resident #1 and she was about to be out of them. CNA B stated she was in the room when the DON said Resident #1 was not getting more diapers. CNA B stated Resident #1 was stressed and worried because she said she did not know what to do and that she needed diapers right then and she did not know what to do. CNA B stated Resident #1 needed to be changed right then and Resident #1 said she needed to wait until tomorrow to get a diaper change. CNA B stated Resident #1 was worried. CNA B stated she went and found diapers for Resident #1 from another resident because the DON refused to give Resident #1 diapers and that was the 2nd time she did that. CNA B stated the previous facility Administrator had to help Resident #1 with diapers because the DON does not go into Resident #1's room. CNA B stated the diapers were not accessible to the CNA's. In an interview on 3/8/24 at 1:59 p.m., the Administrator stated there was no certain number of supplies a resident could have. She stated the residents were able to request more supplies if they need it. She stated the staff round every 2 hrs. and they change the residents if they need to be changed. The Administrator stated the CNAs worked 12 hour shifts and if a resident has urinated or had a bowel movement that would be 6 diapers per shift. The Administrator stated the DON was a brand new DON and never been a DON before and she does not know if she had been trained yet. The Administrator that today was the Administrators 2nd day working at the facility. She stated she had not heard that the DON told a resident that she was getting on her nerves and that customer service was number 1 for her. In an interview on 03/8/24 at 6:57 p.m., with Resident #1's family member, she stated she was so furious she thought she was going to pass out and she did not know how to handle it. She stated the DON had such a bully attitude, a real nasty attitude. Resident #1's family member stated how is she going to use 8 diapers until she gets more on Friday and the DON would not give her [Resident #1] any diapers. She stated she thought it was so ridiculous that the DON could not give Resident #1 more diapers. Resident #1's family member stated she was furious and thought it was very wrong to tell her that and for the DON to have the position she has; she is very rude and has a bully attitude and it really upsets her. She stated she thought the DON was extremely rude and that is totally neglect. She explained, What was she to do, she needed to be changed and she could not get a diaper. She stated the DON just walked out of the room while Resident #1 was trying to explain to her, and she would not allow her to explain. She stated the CNA was in the room when she was talking to Resident #1 and she asked the DON if she could get a diaper to change Resident #1 and was told no. She stated, it was extremely, extremely neglectful to have somebody laying needing a diaper change and could not get it. Record review of Resident#2's face sheet dated 3/8/24 revealed she was admitted on [DATE] with a diagnosis of bipolar disorder current episode depressed (extreme mood swings), hemiplegia and hemiparesis (severe or complete loss of strength in the arm, leg and/or the face on one side of the body), cerebral infarction (stroke-damage to the issue in the brain due to a loss of oxygen), asthma, type 2 diabetes (high blood sugar), congenital malformation of esophagus (birth defect where the tube that connects the mouth to the stomach does not develop properly), osteoarthritis (degenerative joint disease), major depressive disorder, obstructive sleep apnea, overactive bladder, and right upper quadrant pain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #2's MDS assessment dated [DATE] revealed a BIMS Summary Score of 11 indicating moderate cognitive impairment. Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's undated care plan revealed resident had chronic pain r/t cerebral vascular accident, uses antidepressant medication r/t depression, communication problem r/t neurological symptoms with interventions to anticipate and meet needs, be conscious of resident position when in groups, activities, dining room to promote proper communication with others, discuss with resident/family concerns or feelings regarding communication difficulty, Encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express. Monitor for/record confounding problems: decline in cognitive status, mood, decline in ADL, deterioration in respiratory status, oral motor function, hearing impairment (ear discharge and cerumen (wax) accumulation, poor fitting/missing dental appliances etc. Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. Monitor/document/report to MD PRN changes in: Ability to communicate, Potential contributing factors for communication problems, Potential for improvement. 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. Refer to speech therapy for evaluation and treatment as ordered. Use communication techniques which enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures and validate resident's message by repeating aloud. In an interview on 3/8/24 at 10 a.m. with Resident #2 she stated the DON says sometimes she get on their nerves .Resident #2 explained that the DON stated that she [Resident #2] was getting on her nerves and said it in a mean way. Resident #2 stated she told the DON you know I don't appreciate it, and don't talk to her like that. Resident #2 stated the DON gets upset. Resident #2 stated that it made her feel bad and that it was serious to her. She stated the DON told her more than one time that she was getting on her nerves (unknown dates) and she told the DON don't treat her like that. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an observation and interview on 3/8/24 at 12:50 p.m. with the DON of the diaper supply in the central supply room she stated the residents received 2 bags of diapers for the weekend and she puts in gloves, wipes, and chucks. She stated she ordered weekly or biweekly what she needed, but this was her first time putting an order in. The DON stated she passed out 1 pack of diapers on Mondays and Wednesdays and 2 packs of diapers on Fridays. The DON stated on Wednesdays she gave out diapers only as needed. The DON stated everyone received 2 packs of whatever size diapers they wear, and the residents receive diapers according to weight and Resident #1 wore a size 3x. The DON stated size 3x had 8 diapers in it, large had 18 diapers, 4x and 5x had 8 diapers in a pack, and medium had 24 diapers in a pack and the residents receive 2 packs so that they do not run out. The DON stated she was giving Resident #1 diapers (to last from Friday to Monday) because the diapers were more absorbent than the large ones. The DON stated she did not tell Resident #1 she was not giving her any more diapers because she did not even go in her room anymore. The DON stated she gave the same number of packs of diapers to each resident more than once and double on the weekends. The DON stated on Monday Resident #1 received 1 pack and sometimes Resident #1 did not need any diapers on Monday. The DON denied telling Resident #1 that she was not giving her any more diapers because she did not go into her room anymore, per Resident #1's request. The DON stated since she had been there, Resident #1 had not run out of diapers because she passed them out herself and she denied telling Resident #2 that she got on her nerves, exclaiming wow, absolutely not. The DON stated she had only made 1 order for Central Supply and she did not keep a record of it at all. She stated on February 7, 2024 the facility changed owners. She stated she made her first order last week In an interview on 03/8/24 at 3:12 p.m. with the DON, she explained that the residents probably got changed before breakfast and every 2 hours so there was a diaper change at least 4-6 times per shift and Resident #1 had 8 adult diapers. The DON stated that in one 12-hour shift, Resident #1 would use at least 6 diapers. The DON stated there was no changing diapers during meals, so 6 diapers is the math of it. She stated they did morning care, after breakfast at around 10 am, after lunch that's a change around 1pm, between 3 and 4 before dinner they will change Resident #1. The DON stated if the CNA did their last round before dinner, they go home at 6 pm and the next shift comes in. She stated the CNA would change Resident #1 at around 8 pm, and with Resident #1 she asks to be changed if they do not change her. She stated they would change Resident #1 in the middle of the night 2 times and between midnight and 4 a.m. Resident #1 was asleep. There are 3 meals in morning shift so there is no change during meals. The DON stated there was a diaper change at least 4 times in a 12-hour shift. She explained that when Resident #1 was on her cycle, a CNA would give Resident #1 a white brief (small), because she liked to line the diapers in her brief. The DON explained that she ordered chucks (bed pads that protect beds and other surfaces from bodily fluids) to benefit Resident #1. In an interview with the Administrator and record review of the DON's employee file on 03/12/24 at 2:05 pm. revealed that there was not a signed Abuse and Neglect document for the DON. The Administrator stated she called the corporate HR to check if there was an electronic copy but was informed that the company did not require that documentation at that time. The Administrator stated she would be implementing that for all current staff and new hires going forward. Record review of in-service for abuse and neglect titled staff development/ Inservice Attendance sheet dated 3/11/24, revealed the DON was present. Record review of in-service for Resident Rights titled staff development/ Inservice Attendance sheet dated 3/11/24, revealed the DON was present. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy titled Coordinating/ Implementing Abuse, Neglect, and Exploitation Policies and Procedures, revised April 2021, stated that: -The administrator is responsible for the overall coordination and implementation of our facility's policies and procedures against abuse, neglect, and misappropriation of resident property. -Any identified deficiencies in process that may lead to abuse, neglect, or exploitation or residents are addressed by the QAPI committee. Record review of the facility's policy titled Resident Rights revised February 2021, stated: -Residents have the right to a dignified existence, to be treated with respect kindness, and dignity, and to be free from abuse, neglect, misappropriation of property, and exploitation.