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	08/25/2025

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

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to protect the resident's personal privacy during personal care for 1 (Resident #5) of 7 residents reviewed for privacy.- CNA I failed to provide privacy during incontinence care for Resident #5 whose naked buttocks were completely exposed and seen through the window by Surveyor walking by.This failure places residents at risk for embarrassment and a lack of privacy.Findings included:Record review of Resident #5's undated face sheet revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of atherosclerotic heart disease (blockage in the arteries to the heart), cognitive communication deficit, lack of coordination, muscle weakness, and problems following cerebrovascular disease (disorders affecting the blood vessels/blood supply to the brain).Record review of Resident #5's Annual MDS assessment dated [DATE] revealed a BIMs score of 15 out of 15 which indicated normal cognition. He had an impairment on one side of his upper extremities and an impairment on both sides of his lower extremities. The resident was substantial/max assist (Helper does more than half the effort) with all ADLs and was incontinent of bowel and bladder. Record review of Resident #5's care plan dated 6/24/22 revealed the following care areas: *Focus: Resident #5 had bladder incontinence. The goal was to remain free from skin breakdown due to incontinence through the review date. Interventions included changing the resident every 2hrs and PRN and establish voiding patterns. *Focus: Resident #7 had potential for alteration in bowel function/incontinence and/or constipation. The goal was to not develop any GI complications. Interventions included keeping the resident clean and dry, and keeping the call light in reach. *Focus: The resident had an ADL self-care deficit r/t R BKA. The goal was to maintain current level of function through the review date. Interventions included Personal Hygiene: The resident required staff participation with personal hygiene, the resident required staff participation to reposition and turn in bed, and the resident required staff participation to use the toilet.In an interview and observation on 8/12/25 at 1:56pm, CNA I was providing incontinence care to Resident #5 without the privacy curtain drawn and the Surveyor saw Resident #5's whole backside exposed through the window while walking down the hall. CNA I said the privacy curtain was stuck, and she could not pull it all the way around. She said she should have pulled harder instead of going ahead and changing the resident. She said she would be embarrassed if that happened to her and she had been trained on privacy/dignity.In an interview on 8/12/25 at 2:00pm, Resident #5 said he did not know he was exposed during incontinence care. He said CNA I normally would pull the privacy curtain all the way around. He said, He did not see it when asked if it bothered him that he was exposed during incontinence care.In an interview on 8/12/25 at 4:47pm, the ADM said she expected staff to pull the privacy curtain all the way around and close the door before performing incontinence care for the privacy of the residents.Record review of the facility's policy and procedure on Perineal Care, undated, read in part: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible ' and to prevent and assess for skin breakdown. Provide privacy by pulling privacy curtain or closing room door if a private room.Record review of the facility's policy on Promoting/Maintaining Resident Dignity, undated, read in part: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Maintain resident privacy. Random observations and/or verifications are conducted by the Director of Nursing Services (DNS), or designee, to ensure compliance with this policy.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 5 of 33 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #6) reviewed for quality of care.The facility failed to perform weekly skin assessments on the residents for several weeks.This failure could place residents at risk for skin breakdown and/or wounds without receiving treatment or worsening of skin breakdown or wounds.Findings included:1. Record review of Resident #1's undated face sheet revealed she was a [AGE] year-old female admitted originally on 5/21/21, with the most recent admission being 7/25/25. She had diagnoses of type 2 diabetes mellitus (body does not produce insulin or resists it), stage 3 pressure ulcer (fat is visible, but not bone), cognitive communication deficit (difficulty in communication due to attention or memory), hemiplegia of left side (paralysis), contracture of right lower leg (shortening or tightening of muscles, tendons, or ligaments), contracture of left lower leg, and dementia (decline in mental ability affecting daily life).Record review Resident #1's Quarterly MDS assessment dated [DATE], revealed a BIMs score of 4 out of 15 which indicated severely impaired cognition. The resident had impairment on both sides of her upper and lower extremities and was dependent (helper does all of the effort) with all ADLs. The MDS revealed the resident had a Stage 3 pressure ulcer, and a Stage 4 (exposed bone, tendon or muscle) pressure ulcer. She also had 2 unstageable pressure injuries. Record review of Resident #1's care plan dated 5/22/21 revealed the following: *Focus: Resident had a Stage 3 pressure injury of the L Lateral Knee (outside of the knee) that was now a Stage 4 pressure injury after being readmitted from the hospital on 7/25/25 (Initiated: 9/5/24, Revised: 8/2/25). The goal was for the resident to remain free from further breakdown. An intervention was conducting weekly skin assessment per facility policy. *Focus: Resident had impaired physical mobility r/t decreased ROM to L hand (Initiated: 11/21/24). The goal was to reduce further contraction through next review. Interventions included monitoring R hand skin integrity, circulation, and motion. *Focus: Resident had a pressure ulcer/DTI to the L medial (inside) heel after readmission from the hospital on 7/25/25 (Initiated: 4/23/25, Revised: 8/2/25). The goal was to remain free from further breakdown through the review date. Interventions included skin assessment to be completed per facility policy and conduct a weekly skin inspection. *Focus: Resident had a pressure injury to the L plantar (bottom) foot (Initiated: 8/5/25). The goal was for her skin to remain intact through the review date. Interventions included conducting a weekly skin inspection and diabetic foot monitoring. *Focus: Resident had pressure injury to R Ischium (hip) on readmission 7/25/25 (Initiated: 7/25/25, Revised: 8/2/25). The goal was to show s/s of healing through the review date. Interventions included monitoring for tissue breakdown, monitoring for infection, and notifying MD if necessary. *Focus: Resident had pressure injury to R dorsal great toe (top of big toe) on readmission 7/25/25 (Initiated: 7/25/25, Revised: 8/2/25). The goal was to show s/s of healing through the review date. Interventions included monitoring for tissue breakdown and monitoring for infection.Record review of Resident #1's Physician Orders from 8/12/25, revealed an order from MD J for weekly head to toe skin assessments every night shift on Tuesdays, which was ordered on 7/25/25 to start on 7/29/25. Record review of Resident #1's medical records revealed an initial skin assessment was performed on re-admission 7/25/25 at 11:56am. Record review of Resident #1's assessments on 8/12/25, revealed the weekly wound reports were being performed.Record review of Resident #1's July 2025 MAR-TAR revealed LVN P initialed that she performed the skin assessment on 7/29/25. No weekly skin assessment for 7/29/25 was found in the resident's chart.Record review of Resident #1's August 2025 MAR-TAR revealed LVN P initialed that she performed the skin assessment on 8/5/25. No weekly skin assessment for 8/5/25 was found in the resident's chart.In an observation and interview on 8/12/25 at 2:10pm, a skin assessment was performed on Resident #1 by LVN G and CNA I. No new skin issues were found. There were wounds on the resident's L thigh, L knee, R toe, and R hip. Per LVN G, the wounds were already being treated by wound care. The resident was not interviewable. 2. Record review of Resident #2's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of ESBL (type of multi-drug resistant organism) resistance, prediabetes, paraplegia (paralysis of lower extremities), cognitive communication deficit (difficulty in communication due to attention or memory), bipolar (mood swings ranging from depressive lows to manic highs), and depression.Record review of Resident #2's admission MDS assessment dated [DATE] revealed a BIMs score of 15 out of 15 which

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents received care, consistent with professional standards of care to prevent the development of pressure ulcers for 1 of 7 (Resident #7) residents reviewed for pressure ulcers. - The facility failed to prevent Resident #7 from acquiring DTIs to both of her heels and from the L heel progressing into an unstageable PU, when she was admitted with only redness to both heels. Resident #7 required hospitalization for the treatment of the injuries to her heels.An Immediate Jeopardy (IJ) was identified on 8/21/2025. The IJ template was provided to the facility on 8/21/2025 at 12:55pm. While the IJ was removed on 8/22/2025 at 4:00pm, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.This failure could place residents at risk for pain, infection, and hospitalization.Findings include:Record review of Resident #7's undated face sheet revealed she was an [AGE] year-old female admitted on [DATE] with diagnoses of type 2 diabetes (body does not make insulin or resists it), retention of urine, osteoarthritis (joint disease where cartilage breaks down), neuropathy (nerve pain), and difficulty walking.Record review of Resident #7's admission MDS assessment dated [DATE] revealed a BIMs score of 15 out of 15 which indicated normal cognition. She had an impairment on both sides of her upper and lower extremities. The resident was partial/moderate (helper does less than half the effort) assistance with ADLs. She had an indwelling catheter and was incontinent of bowel. The MDS revealed the resident had no pressure injuries on admission.Record review of Resident #7's admission and Baseline Care plan dated 6/30/25 revealed the resident had redness to her right and left heel on admission, with no DTIs or open wounds to her heels. Resident #7 admitted with a wound to the sacrum but there was no evidence of it worsening.Record review of Resident #7's care plan dated 6/30/25 revealed a Focus: Resident #7 admitted with DTI of the L heel (Initiated 6/30/25, Revised 7/30/25). The goal was to remain free from further breakdown through the next review. Interventions included floating the heels, heel boots, weekly skin inspection, and treatments as ordered. Focus: Resident #7 admitted with DTI of the R heel (Initiated: 6/30/25, Revised: 7/30/25). The goal was to remain free from further breakdown through the next review. Interventions included weekly skin inspections, float the heels, heel boots, and treatments as ordered.Record review of Resident #7's previous hospital's Initial admission Physical assessment dated [DATE] at 10:19pm, revealed redness to the sacrum (tailbone), but no wounds and no mention of redness or any concerns to the heels.Record review of Resident #7's previous hospital's Wound Care Consult dated 6/24/25 at 12:42pm, revealed she had .sacral blanchable [turns white] redness over intact skin.Bilateral lower extremities with edema [swelling].no open wounds. Bilateral feet had palpable [able to feel] pulses. No other alterations to skin integrity noted.Record review of Resident #7's previous hospital's Shift Physical assessment dated [DATE] at 9:00am, revealed her exception to a normal skin assessment was having swollen bilateral legs. There was no mention of any other skin issues.Record review of Resident #7's Progress Note dated 7/1/25 at 1:14pm by LVN W, revealed the resident had pressure ulcers on her sacrum and Wound Care was consulted. Nothing was noted about the heels having wounds.Record review of Resident #7's Physician Orders revealed the following orders from MD M:- Consult Wound Care. Ordered on 7/1/25.- Wound Care: Cleanse R Heel with NS, Pat dry, Apply skin prep to wound and LOA, QD. Ordered on 7/9/25 at 6:00am.- Wound Care: Cleanse L Heel with NS, Pat dry, Apply skin prep to wound and LOA, QD. Ordered on 7/10/25 at 6:00am.- Use Heel Lift to float heels at all times while in bed, every shift. Ordered 7/10/25 at 2:00pm.- May send to [hospital] for eval and tx, one time. Ordered on 8/3/25 at 8:30pm.Record review of Resident #7's Weekly Head to Toe Skin Check dated 7/7/25 at 12:34pm by LVN C, revealed L heel with no description and no mention of the R heel. Under the weekly heel check questions LVN C answered the L heel was not boggy (mushy), not discolored, did not have an open area, and did not have a blister. Record review of Resident #7's Wound Care Note dated 7/8/25 at 4:39pm from MD O, revealed the resident had a R heel deep tissue injury that was 3cm x 4cm x 0cm. She also had a L heel deep tissue injury that was 3cm x 3.5cm x 0cm.Record review of Resident #7's Weekly Head to Toe Skin Check dated 7/14/25 at 12:38pm by LVN C, revealed R heel DTI and no mention of the L heel. Under the weekly heel check questions LVN C answered the L heel was not boggy, it was discolored, did not have an open area, and did not have a blister.Record review of Resident #7's Wound Care Note dated 7/15/25 at 9:11pm from MD O, revealed the R heel DTI was 3.2cm x 3.5cm x 0cm. The L heel DTI was 4cm x 4.5cm x 0cm Record review