STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676481	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lavaca Bay Nursing and Rehabilitation Center	118 Trinity Shores Drive Port Lavaca, TX 77979

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 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 interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 6 residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1's skin assessments dated 11/13/2025 and 11/25/2025 accurately reflected a bruise on his knee or the bruise on his cheek. The facility failed to accurately document skin issues on Resident #1 according to his care plan. This failure could place residents at risk of inadequate care due to an inaccurate skin assessment. Findings include:Record review of Resident #1's face sheet, dated 11/25/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental function), heart failure, chronic obstructive pulmonary disease (chronic progressive lung disease), type 2 diabetes mellitus without complications (high blood sugar), major depressive disorder (mental health disorder characterized by persistent depressed mood), hypertension (high blood pressure), delusional disorder (serious mental illness that causes unshakeable false beliefs for at least a month), and dementia (memory, thinking, difficulty). Record review of Resident #1's quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 99, which indicated unable to complete the interview. Record review of Resident #1's care plan, dated 10/07/2025, revealed Resident #1 was at risk of falls. The care plan also revealed Resident #1 has episodes where he will move from his bed to the floor mat beside his bed. Sometimes he is found kneeling beside the bed in a praying position and sometimes he will lay all the way down on the floor and put his pillow under his head. Resident #1 has an ADL self-care performance deficit related to shortness of breath, Alzheimer's, Dementia, limited mobility. Interventions were The resident requires (EXTENSIVE ASSISTANCE) by one staff to turn and reposition in bed. The care plan also revealed resident requires SKIN inspection. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Record Review of Resident #1's skin assessment dated [DATE] revealed that Resident #1's bruise on his knee and the bruise on his left cheek was not on the assessment. Record review of Resident #1's skin assessment completed by LVN A, dated 11/25/2025 at 10:03a.m., revealed Resident #1's bruise that covered his whole knee was not reported on the skin assessment. The skin assessment also did not have the bruise on his left cheek bone. Observation of Resident #1's peri-care on 11/25/2025 at 12:49p.m., revealed that Resident #1 had a bruise on his right knee. The bruise covered most of his kneecap; was yellow and purple. The bruise on Resident #1's cheek was dark purple. During an interview with Resident #1's RP on 11/25/2025 at 10:55a.m., revealed that his father falls a lot because of his dementia. He said he had a fall and was on his knees, he believed that was possibly how his father got the bruise on his knee. He said that he did not feel like his father was being abused or neglected. He said he visits Resident #1 often and feels like he is being taken care of. During an interview with the TN on 11/25/2025 at 4:00p.m., she said she was notified of the bruises on Resident #1's knee and on his face that morning. She said the CNA should have seen the bruise on Resident #1's knee when he was given a shower. She also said when the nurse did the skin check that morning, she should have seen the bruise on his knee and on his face. She said the nurse should have documented the bruises on the skin assessment. When asked how an inaccurate skin assessment could affect Resident #1, she said she did not know how to answer the question. She said she was responsible for monitoring to ensure the nurses were completing the skin assessments correctly. She said the treatment nurse monitored the skin assessments. She said the treatment nursed monitored by running a report to check that skin assessments are done correctly. She said skin assessments were supposed to be done weekly. She also said CNAs should report any skin issues to the nurse. She said she did not know why the bruises were not reported. During an interview with CNA B on 11/25/2025 at 4:34p.m., she said she was supposed to check for any skin issues when she gave a resident a bath. She said she worked with Resident #1 all the time. She said she did not notice the bruise when she worked three days prior. She said the nurse saw the bruise on Resident #1's face that morning after shift change. She said the previous CNA did not report any skin issues to her during shift report. She said the CNAs were responsible for reporting skin issues to the nurse. She said if skin issues were not reported the resident may not get the proper care. She said that she did not know how Resident #1 got the bruise on his knee or the one on his face. During an interview with LVN A on 11/25/2025 at 4:54p.m., revealed that she did not know about the bruise on Resident #1's knee. She said the nurses were supposed to do skin assessments once a week on all