STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675323	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baywind Village Skilled Nursing & Rehab	411 Alabama Ave League City, TX 77573

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on interview and record review, the facility failed to notify the resident representative when the resident experienced a significant change in condition for 1 (CR #1) of 5 residents reviewed for resident rights. The facility failed to notify CR #1's Responsible Party when she had a hypotensive event and refused to go to the hospital. This failure could result in the resident representative not being aware of conditions that may require them to make medical decisions. Findings included: Record review of CR #'1s face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: fracture of unspecified carpal bone right wrist, hypo-osmolality and hyponatremia (a condition where the body retains water and sodium levels in blood are lower than normal), and hypertension. The family member was listed as the Responsible Party and Power of Attorney-care, care conference person, and HIPPA for CR #1. Record review of CR #1's initial MDS assessment dated [DATE] revealed CR #1 had a BIMS of 15 indicating she was cognitively intact and could make her own decisions. Record review of CR #1's care plan revised on 4/29/24, read: CR #1 had an ADL self-care performance deficit r/t right wrist fracture, she required assistance with bathing, bed mobility, eating, toileting, and transfers. CR #1 was on Montelukast Sodium r/t allergies, the intervention for this medication was listed as a black box warning which meant it could cause serious life-threatening risks, disability, and result in hospitalization or death. CR #1 had potential fluid deficit r/t diuretic use, at moderate risk for falls, and on diuretic therapy (Lasix) r/t edema. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's progress notes dated 4/28/24 at 12:46 am created by RN A read: patient attempted to get up to go to the restroom and face appeared pale, patient complained of feeling nauseated, patient was slow to awake, took a set of vital signs and they were all within normal limits except BP (blood pressure) 71/54 and HR (heart rate) 109. CNAs assisted patient in a laying position in bed. A cool, damp towel was applied to forehead and neck of patient. Hydration was offered and given. On-call voicemail left for MD (medical doctor) regarding event. Patient educated on using the call light if needed to leave her bed and assistance with ADLs. MD wants patient sent to ER for further evaluation; 1:42 am, Called Priority Care Transport 3 times, no answer. Left a voicemail for pickup of patient as MD asked that she be sent out to further evaluation due to hypotensive event. Unable to print patient document due to printer system currently offline; 1:50 am, 911 called for patient to be taken to hospital as no return call from transport service has been received; 2:15 am, Patient refused to leave with 911 transportation, they took 12-lead EKG (electrocardiogram) and vital signs, they were all within normal limits. Suggested she keeps taking fluids to combat possible dehydration s/s. Educated patient on risks of not going to hospital to be checked out. Patient still refused to leave with 911 transport. Patient stated, 'I feel fine I just need to drink some more water'. MD made aware; 6:26 am, Patient BP and HR is now stable and within normal limits . Record review of CR #1's progress notes dated 4/28/24 at 9:18 am created by RN B read: Resident was using the bathroom with CNA around 8:05 am this morning. Resident started to feel lightheaded, and the CNA brought the wheelchair for the resident to sit in. Upon sitting, resident was noted to start salivating and had seizure-like activity witnessed by CNA. Vitals were taken. BP 72/52, HR 128, 99% O2 (Oxygen) saturation, 179 blood glucose. MD on call was called around 08:15 am and notified of resident's status. Resident was sent to local hospital via emergency transportation. Family was also notified of resident status, as well as departure time from the facility. Resident alert and oriented x4. No complains of pain. Departure around 9:10 am in stable condition. Interview on 5/4/24 at 12:24 pm with CR #1's Responsible Party, she said no one notified her of CR #1's condition Saturday night (4/27/24), nor Sunday morning (4/28/24). She said CR #1's phone was across the room, and she was unable to reach her phone. She said CR #1's roommate assisted her with her phone so she could call her family. She said when CR #1 was on the phone with her, she heard someone in the background say, are you aware the patient had a seizure. The RP said that was how she found out about CR #1s condition. She said when CR #1 was at the hospital, her hemoglobin had dropped down to 3 and was given 11 blood transfusions. She said CR #1 had multiple stomach ulcers that ruptured. She said CR #1 had a breathing tube in place and on Tuesday, 4/30/24, the family made the decision to take the breathing tube out. She said if she was notified the night (4/27/24) when CR #1 refused to go to the hospital, she might have lived. She said she and the family lost time with her because they were not notified right away. Interview on 5/4/24 at 12:44 pm with the Administrator, he said RN A got an order to send CR #1 to the hospital. He said CR #1 refused to go to the hospital and stated she needed water. He said staff failed to notify the family that night of the change in condition. He said CR #1 called her family the next morning about 6 to 8 hours after she refused to go to the hospital. Interview on 5/4/24 at 2:38 pm with the DON, she said if a change in condition occurred with a patient, the RP would need to be notified. She said the expectation was to notify the RP. She said notifying the RP was a courtesy. The DON said RN A was counseled on 4/30/24 to notify the RP when a change in condition occurred with a resident and an in-service was conducted on 4/28/24 for staff on notifying the RP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/8/24 at 4:01 pm with RN A, she said she had been working at the facility for a month. She said on 4/28/24 CNA A reported to her that she tried to sit CR #1 up in the bed, but she fell back in the supine position. RN A said she performed a neuro check and conducted vitals. She said she notified the on-call physician. She said the on-call physician told her CR #1 was having a hypotensive event and wanted CR #1 to go to the ER. She said she called their emergency transport service 3 to 4 times, and they never answered or called back. She said she called 911. She said she let CR #1 know she called 911 and CR #1 told her she did not want to go to the hospital because she would be going home in a few days. She said when the 911 paramedics arrived, they performed an EKG, assessment, and took vitals. She said all resident's vitals were normal. She said CR #1 refused to go to the hospital, so the paramedics left. She said she checked on CR #1's vitals every 1 to 2 hours and made sure she stayed hydrated. She said she left between 7am to 7:30 am and CR #1 was in the facility at that time. She said she did not notify the RP because she was not trained to do that. She said because CR #1 had a high BIMS (15) score, and she did not think she had to notify anyone. She said going forward she knew to notify the RP. Interview with the ADON on 5/24/24 at 9:07 am, she said when there is a change in condition with the resident, the resident needed to be assessed, get vitals, notify the physician, follow physician orders, and notify the resident's family. The ADON said the risk to the resident if any of these steps are missed in this process would be detrimental to the resident. The ADON said it if important to contact family if the resident refused to go to the hospital because, the family can tell the resident in a different way than staff and can change the reaction of the resident to go to the hospital, the family can offer comfort to the resident. If a resident still refused, she would notify the physician. Record review of the Change in a Resident's Condition/Status Policy dated February 2021 read in part . our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status . unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status .

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on interview and record review, the facility failed to provide and document adequate preparation to residents to ensure safe and orderly transfer or discharge from the facility, for 1 (CR #2) of 3 residents reviewed for transfer/discharge. The facility failed to ensure CR #2 was discharged with Home Health Services in place. This failure could place residents at risk of being discharged without preparation, causing a disruption in their care and services. Findings included: Record review of CR #2's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: asthma with acute exacerbation, sepsis, hyperlipidemia, local infection of the skin and subcutaneous tissue, xerosis cutis (abnormally dry skin), Stage 4 pressure ulcer of sacral region, chronic gout, muscle weakness, neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), urinary tract infection, cognitive communication deficit, anxiety disorder, multiple sclerosis, aphasia (loss or ability to understand or express speech), and transient ischemic attack (a brief stroke-like attack). Record review of CR #2's care plan dated 4/4/24 revealed CR#2 was care planned for the following: 2-person assist for turning and repositioning in bed, supervision when eating, 2-person assist to move between surfaces as necessary, stage 4 pressure ulcer, indwelling catheter and colostomy bag. Record review of the discharge summary dated 4/25/24 read in part . skilled nursing facility patient seen today for follow-up to discharge home with home health services for continued rehab and wound care today, no new acute complaints . Record review of CR #2's progress notes dated 4/25/24 at 4:31 pm entered by DON revealed: resident discharged home via transportation provided by facility. Bed and wheelchair ordered for home use. Resident stable and in good spirits upon discharge. Medications called in to pharmacy. Record review of CR #2's progress notes dated 4/29/24 at 3:57 pm entered by Discharge Planner Assistant revealed: patient's family member called to check on his home health care coming out to see him today. Discharge Planner called home health agency to confirm the admission, they let her know the patient was not admitted due to his plan only covering 50% off the services he needs, they also sent his referral to other companies who also returned with the same response. Patient's family member then replied, 'This is what I meant by him being prepared to go home.' Discharge planner advised her that she would need to change his plan to receive full coverage benefits. It is unclear if she understood what was being explained because she then replied 'So, I would have to find a home health company myself and have ya'll give me an old order so they can take him?' Discharge planner reiterated the sentiment again and let her know we are waiting on one last company to respond. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CR #2's family member on 5/9/24 at 6:10 pm, she said the facility did not plan the discharge for CR #2. She was told by the Discharge Planner Assistant on Monday, 4/22/24 that CR #2's insurance will stop paying for his care and he would be discharged on Thursday, 4/25/24. She said the facility started looking for a home health the day of his discharge. She said CR #2 was brought to her home in a car. She said the person that dropped him off left him at the door and did not assist her family members to bring CR #2 in the house. The family member said her relatives were providing care for CR #2 until a home health agency took over. She said her relatives knew how to care for CR #2 because he used to be on hospice and the hospice agency taught them how to provide care for CR #2. The family member said she was the one that found a home health agency for CR #2 and CR #2's home health services started on 5/8/24. Interview with the Discharge Planner on 5/10/24 at 11:27 am, she said she had worked at the facility for 7 years. She said CR#2 discharged on [DATE]. She said she offered the family member to appeal but the family member told her 'I'm not going to appeal as long as the facility has everything in place for his home healthcare'. The Discharge Planner said her assistant was initially assisting the family member, but she had to step in. She said one of CR #2's family member spoke to the Admissions Assistant to take care of the supplies that he needed. She said the Admissions Assistant was not in charge of this process, she oversaw the admission paperwork. CR #2's family member did not want to tell the Discharge Planner what supplies were needed so the Discharge Planner guessed at what type of supplies CR #2 needed. The Discharge Planner said the home health agency contacted her the day after CR #2 discharged and told her they could not take him because his insurance only covered 50%. She said every home health she called the coverage had to be at least 80%. She said a different home health agency was the only one that was able to take care of him. She said CR#2 did not have transportation benefits either, the facility paid for his transportation to get home. The family member did not want to change the plan level of coverage for the insurance. She told the family member she could get CR#2 started on home health but they would need to pay for the other half that the insurance did not cover. Interview on 5/10/24 at 12:13 pm with an admission agent from the home health agency, she said they could not accept CR #2 because they did not service his area. She said the orders for CR#2 were faxed over to her on 4/26/24. Interview on 5/10/24 at 12:27 pm with an admission agent from the home health agency that accepted CR #2, she said the initial orders for CR #2 came in on 4/29/24 and his services started on 5/8/24. Interview with the Discharge Planner on 5/10/24 at 2:15 pm, she said CR #2s insurance owns the home health agency that CR #2 was rejected from. She said any patient who had the same Insurance as CR #2, she would refer them the home health agency and never had any issues in the past. She said the orders for CR #2 were dated for 4/23/24 and was not sure why the fax did not go through until 4/26/24. She said this was the first time that she heard CR#2 did not have home health. Interview with the Assistant Administrator on 5/10/24 at 2:41 pm, she said discharge planning should start the day of admission. She said in the past the facility has held discharges for patients because home health was not in place. She said the Discharge Planner should have come to her or the Administrator to let them know there was no confirmation of home health. She said the failure happened with the Discharge Planner not getting the confirmation with home health and re-education needed to be done. She said the risk to the resident would be they would not have the supplies or the care they need. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Transfer or Discharge Policy dated December 2016 read in part . residents will be prepared in advance for discharge . a post-discharge plan is developed for each resident prior to his or her transfer or discharge . this plan will be reviewed with the resident, and/or his or her family, at least twenty-four hours before the resident's discharge or transfer from the facility .