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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675323 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/16/2025 |
| NAME OF PROVIDER OR SUPPLIER Baywind Village Skilled Nursing & Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867</p> <p>Based on interview, and record reviews the facility failed to ensure the residents had the right to be free from abuse for 1 of 6 residents (CR#1) reviewed for abuse.</p> <p>The facility failed to ensure CR#1 was free from abuse when CNA A physically abused CR #1 on 04/24/24 and threatened CR #1's roommate.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 04/24/24 and ended on 04/24/24. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of being abused.</p> <p>Findings included:</p> <p>Record review of CR #1's admission record dated 04/15/25 revealed a-95-year- old female admitted to the facility admitted to the facility on [DATE] with diagnoses that included Essential hypertension (High blood pressure), chronic kidney disease, heart failure, chronic obstructive pulmonary disease, anxiety disorder, dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Record review of CR #1's comprehensive care plan dated 03/17/23 with a revision date of 02/24/24 indicated she had no history of physical aggression and depended on staff for ADL care, meeting her emotional, Intellectual, physical, and social needs.</p> <p>Record review of CR #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 00, which indicated she had severely impaired cognition.</p> <p>Record review of intake incident dated 04/24/24 revealed resident's roommate called out for the nurse and reported that CR #1 had been abused by the CNA A. She stated the curtain was closed, but she could hear the abuse.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of a Nurse's notes dated 04/24/24 revealed in part Resident's roommate called this nurse into the room and stated that resident had just been abused. Resident was noted to be holding her wrist. When nurse moved her hand away, there was a significant amount of bruising to front and back of wrist. Roommate reports she didn't see what happened, but she could hear it. She stated she could hear the CNA hurting the resident. She states she threatened her as well, telling her not to use her call light again. Resident Unable to give description of event.</p> <p>In an interview with the DON on 04/15/24 at 3:00 PM, she said the incident happened almost a year ago. She said CNA A was an agency staff and as soon as the incident was reported by resident's roommate, CNA A was walked out of the facility and was placed on a do not returned list and was never allowed to work at the facility. She said the contract agency was immediately informed and the local police was called. She said the DON immediately had in-service with all staff and encouraged all resident to report any form of abuse to the facility Administrator. She said CNA A denied the allegation and stated that she did not abuse CR #1.</p> <p>During an interview with CR#1's RP on 04/16/25 at 12:20PM, she said she was called by the DON and told her that CNA A had abused her family member and when she filed charges, she was told by the DA office that there was not enough evidence for the case. She said the DA's office dismissed the case for lack of evidence.</p> <p>In an interview with the Assistant Administrator and the Administrator on 04/16/25 at 4:45PM, the Assistant Administrator said the facility did all that they were expected to do at the time of the incident. She said the local police department was notified, Resident's responsible party was notified, and the employee was immediately terminated.</p> <p>The noncompliance began on 04/24/24 and ended on 4/24/24. The facility had corrected the noncompliance before the investigation began.</p> <p>The surveyor confirmed PNC had been implemented sufficiently to remove the deficiency by:</p> <p>Facility notification of abuse incident to responsible party, MD, Ombudsman, local law authority and HHSC.</p> <p>Completion of in-services on abuse.</p> <p>The facility had conducted a safety survey with all residents on the hall that CNA A was assigned.</p> <p>Staff and management recognized the steps to report abuse and neglect.</p> <p>Termination of confirmed perpetrator.</p> <p>Record review of facility's abuse prohibition policy undated page 23-24 revealed,</p> <p>RESIDENT ABUSE/NEGLECT REPORTING</p> <p>(continued on next page)</p> | | |

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| F 0600 Level of Harm - Actual harm Residents Affected - Few | <p>It is the policy of this facility that all personnel promptly report any incidents or any suspected incidents of resident abuse/neglect, including injuries of an unknown source. Upon a report of an allegation of resident abuse/neglect, the facility will investigate each instance as to determine if the allegation did occur. The facility will report and notify the Texas Department of Human Services as outlined in the State Operations Manual.</p> <p>Any facility staff member who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person must report the abuse, neglect, or exploitation, which includes conduct or conditions resulting in serious accidental injury to resident or hospitalization of residents.</p> <p>Conduct or conditions means a facility practice, actions/inactions by staff or circumstances within a facility resulting in:</p> <ol style="list-style-type: none"> 1. Serious accidental injury to residents: or 2. hospitalization of residents. <p>The person (observing an incident of resident abuse or suspecting resident abuse must immediately rep01t such incidents to the Director of Nursing or Administrator.</p> <p>If both the Director of Nursing and Administrator are unavailable the report should be made to the charge nurse: the charge nurse will be responsible for contacting the Director of Nursing or Administrator.</p> <p>As applied in this policy; the following words have the following meaning:</p> <p>Abuse -Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. This includes verbal, sexual, mental, psychological, physical abuse (including corporal punishment, involuntary seclusion, or any other mistreatment within this definition.</p> | | |