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	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baywind Village Skilled Nuring & 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 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 provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, and a system of medication records that enabled periodic accurate reconciliation and accounting of all controlled medications to meet the needs of 1 of 3 residents (Residents #1) reviewed for pharmacy services. -LVN V and RN E, who signed out control pain medication from the control book, did not sign off on the TAR or MAR that control medications were administered for Resident #1. This failure could place residents at risk of not receiving their medication and drug diversion. Record review of Resident #1's face sheet dated 11/05/25 revealed an [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses which included displacement fracture of base of neck of right femur, subsequent encounter for closed fracture without routine healing (received active treatment for a fracture and was in recovery phase) intracapsular fracture of right femur (a break in the upper part of the right thigh bone that happens inside the hip joint), and dementia (impaired ability to remember, think or make decisions that interferes with doing everyday activities).Record review of Resident #1's care plan, dated 09/29/25, read, .the resident is on pain medication therapy (oxycodone) related to acute pain.Record review of Resident #1's October 2025 order summary report read, Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) give 1 tablet by mouth every 6 hours as needed for Pain - Severe, order dated 09/26/25, and Oxycodone HCl Oral Tablet 5 MG give 1 tablet by mouth one time a day for pain, order dated 10/05/25.Record review of Resident #1's controlled drug receipt/record/disposition form, dated 09/27/25, revealed one oxycodone IR tablet, 5 mg, was signed out on 10/08/25 at 11:23 p.m.Record review of Resident #1's controlled drug receipt/record/disposition form, dated 09/27/25, revealed one oxycodone IR tablet, 5 mg, was signed out on 10/09/25 at 8:00 a.m.Record review of Resident #1's controlled drug receipt/record/disposition form, dated 10/07/25, revealed one oxycodone IR tablet, 5 mg, was signed out at 8 a.m. on 10/09/25.Record review of Resident #1's October 2025 TAR for Oxycodone HCl Oral Tablet 5 mg did not reveal the medication was signed as administered on 10/08/25 for 11:30 p.m., and for 10/09/25 for 8:00 a.m During an observation of the control sheet and interview on 10/29/25 at 4:42 p.m., the DON said LVN V signed out Oxycodone HCl oral tablet 5mg from the PRN count sheet at 11:30 p.m. on 11/08/25. The DON said LVN V did not sign off on the TAR for 11/08/25 at 11:30 p.m. , which could indicate LVN V did not administer the control PRN pain medication to Resident #1. The DON said MA L signed out the control pain medication from the scheduled MA control count sheet for 8:00 a.m. on 10/09/25, and she documented 15 on the MAR, which meant MA L did not administer the medication to Resident #1. The DON also said RN E signed out the same controlled pain medication from the PRN control sheet for Nurses on 10/09/25 for 8:00 a.m., but RN E did not sign off on the TAR. The DON said that if the medication were not signed off on the TAR or the MAR, it would mean the resident did not receive the medication and that it was a medication error. During an interview on 11/29/25 at 5:01 p.m., the DON asked the ADON if she destroyed oxycodone for Resident #1. The ADON said she did not remember destroying any controlled pain medication for Resident #1 in September 2025 or October 2025.During an interview on 11/29/25 at 5:03 p.m., the DON stated that an agency nurse (LVN V) signed off the evening PRN control pain medication in the control book on 11/08/25 at 11:30 p.m., but did not sign on the TAR. The DON said it could imply the pain medication was not administered to Resident #1 on 11/08/25 at 11:35 p.m. because it was not signed on the TAR as administered. The DON said two nurses, or the aide, should have destroyed the medication, documented on the count sheet that the medication was destroyed, and signed off on the control count sheet. The DON said medication should be signed off on the control count sheet, and after the nurse or MA administered the medication, the nurse or MA should sign off on the MAR or TAR. The DON said it was a medication error because LVN V and RN E signed off the control pain medication on the count sheet, and LVN V and RN E did not sign on the MAR or TAR.During an interview on 11/05/25 at 8:49 a.m., the ADON said when LVN V and RN E signed off on control medication from the narcotic book, they should also sign off on the MAR or TAR after administering the medicine to Resident #1. She said that if LVN V and RN E did not sign off on the MAR or TAR after administration of the control pain medication, it meant the medication was not administered. She said Resident #1 could still be in pain. The ADON said two nurses or medication aides have to destroy any controlled medication, and both staff would sign off on the control book that the medication was destroyed.During a telephone interview on 11/05/25 at 10:01 a.m., MA L said