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	05/22/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, dispensing and administering of controlled medications and a system of medication records that enabled periodic accurate reconciliation and accounting of all controlled medications to meet the needs of 2 of 3 residents (Residents #1 and Resident # 2) reviewed for pharmacy services.Med Aide B signed out a controlled pain medication from the narcotic control book, did not sign off on the Electronic Medical Administration Record that a controlled medication was administered for Resident #1. LVN A signed out a controlled antianxiety medication from the narcotic control book, did not sign off on the Electronic Medical Administration Record that a controlled medication was administered for Resident #2. These failures could place residents at risk of not receiving their medication or receiving double dosage of controlled medications and drug diversion.Findings:Record review of Resident #1's face sheet dated 05/22/2026 reveled a [AGE] year old female admitted to facility on 03/02/2026 with diagnoses including Alzheimer's Disease with late Onset (irreversible progressive brain disease causing decline in memory, thinking and reasoning skills), Dementia with other behavioral disturbances (a decline in mental abilities that interfere with daily life with changes in personality and actions), neuralgia (nerve pain that is intense, sharp, or shooting pain that travels along a damaged or irritated nerve), neuritis (nerve inflammation that causes swelling or irritation which causes pain, tenderness and numbness) and chronic pain (pain that is long lasting for three months or longer)Record review of Resident #1's care plan read, .the resident is on pain medication therapy (Tylenol #3). Date initiated 8/18/2025. Revision on 4/21/2026. Interventions: Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. Review (EACH SHIFT AND PRN) for pain medication efficacy. assess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required.[sic] Record review of Resident #1's controlled drug receipts/record/disposition form for Acetaminophen W/Codeine Tab #3 revealed a pill was obtained and signed out by Med Aide B for 5/22/26 at 10:00 pm instead of for 5/21/2026 which was the time the med aide was on duty on 200 Hall. Med Aide B failed to document the correct date in the controlled drug receipt/record/disposition form. Record review of Resident #1's May 2026 Electronic Medication Administration Record (EMAR) read, Acetaminophen-Codeine Tablet 300-30 mg, give 1 tablet by mouth every 8 hours for pain. This record review further revealed an omission for signature on 5/21/22 for 10:00pm administration of this medication and no pain level was documented as per physician's order. Med Aide B failed to sign the EMAR for Resident #1 to indicate medication was administered. Record review of Resident #2's face sheet dated 05/22/2026 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses including heart failure (inability of the heart to pump blood effectively), respiratory failure (inability of the lungs to get enough oxygen into the blood and effectively clear out waste gas from lungs) and anxiety disorder (a mental health condition characterized by intense, persistent, and uncontrollable worry or fear about everyday situations). Record review of Resident #2's care plan read, . the resident uses anti-anxiety medications (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	(Buspar/Lorezepam) related to anxiety disorder. Date initiated 04/13/2026. Revision on 05/01/2026. Interventions: .Monitor the resident (EACH SHIFT AND PRN) for safety associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia. Record review of Resident #2's order summary report dated May 2026 read, Lorazepam Oral Tablet 1mg, give 1 tablet by mouth every morning and at bedtime for anxiety/restlessness for 14 days. Order dated 5/14/2026, end date 5/28/2026.Record review of Resident #2's controlled drug receipts/record/disposition form for Lorazepam Tablet 1mg revealed a pill was obtained and signed out by LVN A on 5/20/26 at 11:06 pm. Record review of Resident #2's MAY 2026 EMAR for Lorazepam Oral tablet 1 mg revealed an omission for signature on 5/20/2026 for 7:00 pm administration of this medication. LVN A failed to sign the EMAR for Resident #2 to indicate medication was administered. During an interview on 5/22/26 at 3:55pm and at 4:33pm, ADON stated it is a medication error if a narcotic is not signed off in the EMAR even though it is signed off in the narcotic sheet. She stated if a medication is not signed in the EMAR, then that medication was not administered. ADON stated if a medication error had occurred, the nurse must complete an incident report and notify the physician and resident's family. ADON stated nurse managers do weekly narcotic book audits. She stated they will do a cross match between the narcotic book and the EMAR. During an interview on 5/22/2026 at 4:05pm Med Aide B stated she will sign the narcotic book as soon as she removes a pill from the blister pack. She stated she will click off in the EMAR after she had administered the medication to the resident. Med Aide B stated it is a medication error discrepancy if a narcotic is not signed off in the EMAR. She stated whoever did not sign off in the EMAR may have forgotten to do so. Med Aide B stated she does not think anyone would steal a narcotic because there are cameras everywhere. Med Aide B stated it was important to sign off both the narcotic sheet and the computer. Attempted interview on 5/22/2026 at 4:45pm with Resident # 2 was unsuccessful due to resident asleep. During an interview on 5/22/2026 at 4:50pm, RN C stated she has not received any complaints from residents about not receiving their pain medications or any narcotics. RN C stated she was not aware of any drug diversion in recent times. During an interview on 5/22/26 at 4:56pm, Resident # 1 stated she gets Tylenol # 3 and Lyrica for her neuropathy pain.Resident stated, I'm pretty sure I got my Tylenol #3 last night. During an interview on 5/22/2026 at 5:04 pm, Med Aide B stated when she left work on 5/21/2026 at 10:02 pm, the EMAR on her computer were all green in color indicating she had completed all her medication administration. She stated she checked off the EMAR in both halls where she worked, and they were green. MED Aide B did not have an explanation of how she had missed signing off in the EMAR for Resident #1. Record review of facility policy titled Administering Medication - Nursing Services Policy and Procedure Manual for Long-Term Care 2001 MED-PASS, Inc (Revised April 2019) read in part, .#22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each mediation and before administering the next one.#23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record; a) the date and time the medication was administered. Record review of the facility policy titled Adverse Consequences and Medication Error - Nursing Services Policy and Procedure Manual for Long-Term Care 2001 MED-PASS, Inc (Revised April 2014) read in part, .#5. Medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with the physician's order, manufacturer specifications or accepted professional standards and principles of the professional(s) providing services. #6. Examples of medication errors include: - a) omission - a drug is ordered but not administered;