STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676096	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baybrooke Village Care and Rehab Center	8300 Eldorado Parkway West McKinney, TX 75070

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored securely for one (Resident #1) of five residents reviewed for storage of medications. The facility failed to ensure a bottle of Nystatin topical powder was not left inside Resident #1's room. This failure could place the residents at risk of not receiving medications as ordered by the physician, accidental overdose, or misuse of medications. Findings included: Review of Resident #1's Face Sheet, dated 09/11/2024, reflected that resident was an [AGE] year-old male admitted on [DATE]. Resident #1 was diagnosed with gastro-esophageal reflux disease (stomach acid repeatedly flows back into the tube connecting your mouth and stomach) without esophagitis(inflammation of the esophagus). Review of Resident #1's Comprehensive MDS Assessment, dated 08/23/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment also indicated Resident #1 had gastro-esophageal reflux disease without esophagitis. Review of Resident #1's Comprehensive Care Plan, dated 08/20/2024, reflected the resident was at risk for skin breakdown related to history of rash and the goal was the resident would maintain clean and intact skin. Review of Resident #1's Physician Order dated 08/27/2024, reflected nystatin 100,000 unit/gram topical powder (NYSTATIN) 1 Powder topically (medication applied to the skin) 2 times a day 10 days. APPLY GROIN AND PERIAREA (region between the thighs). The order had a start date of 08/27/2024 and an end date of 09/06/2024. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #1 on 09/10/2024 at 11:39 AM revealed the resident was sitting on his wheelchair and was eating some snacks. In front of the resident was his overbed table where the resident placed a plastic bag for his trash. Beside the plastic bag for trash was a bottle of nystatin powder. Resident #1 stated the medication was for his rashes on his groin. He said the medication was already discontinued and he was not using it anymore. He said he did not know who placed the medication on his table and said he never touched it. Observation and interview with LVN C on 09/10/2024 at 11:46 AM, LVN C stated she administered Resident #1's breathing treatment that morning but did not notice that there was a medication inside the room. LVN C went inside the resident's room and saw the bottle of nystatin power on Resident #1's table. LVN C told the resident she was going to put the medication back to the medication cart. LVN C said there should not be medication inside any residents' room. She said all the medications should be in the cart and the nurses or the medication aides would be the one administering it. She said after the administration of the medication, it should be returned to the medication cart. She said leaving the medication inside the resident's room could result to the medication not being taken by the resident or if the medication being misused. She said she did not leave the medication and did not know who left it inside the room. She said she was just covering for the charge nurse of that hall. In an interview with LVN D on 09/10/2024 at 12:48 PM, LVN D stated she was made aware by LVN C about the medication that was left inside the room. She said she do not have any idea who left the medication inside the room. She said she the order for Resident #1's medication and said it was already discontinued. She said even though the medication was already discontinued, it should not be inside the room because it could result to a lot of unfavorable things. She continued that someone might accidently ingest it. she said the medication was a topical medication and when ingested could result to nausea, vomiting, or abdominal pain. She said the ADON already made a sweep on the rooms of the residents to make sure there were no medications left inside the rooms. In an interview with the DON on 09/11/2024 at 9:37 AM, the DON stated all the medications should be inside the medication carts. She stated the nurses and the medications aide were the one administering the medications. She said Resident #1 did not have an order and a care plan for self-administration of medications. She said she was told the medication was already discontinued. She said she told them the issue was not whether the medications were discontinued or not but why it was inside the resident's room. She said if the resident or a visitor ingested it, there could be adverse reactions. She said nobody could tell her who left the medication inside the room. She said the expectation was no medication would be left inside the room. She said she already did an in-service about medication administration and making sure no medications were left inside the room. In an interview with ADON A on 09/11/2024 at 3:14 PM, ADON A stated the DON instructed her the day before to check all the rooms of the residents if there were medications left inside the room. She said medications, whether oral, nasal, eye drops of topical should be in the medication carts. Those medications were given by the nurses or the medication aide. If a medication was left inside the room, various harmful outcomes could happen. She said the DON already did an in-service about the matter. She said the expectation was for the staff to be mindful and put the medication back to the medication cart where they were securely stored. Record review of facility policy, Storage of Medication Nursing care Center Pharmacy Policy & Procedure Manual revised 05/2016 revealed Policy: Medications and biologicals are stored properly . to support safe effective drug administration.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for six (Resident #2, Resident #3, Resident #4, Resident #5, Resident # 6, and Resident #7) of eighteen residents observed for Infection Control. 1. The facility failed to ensure RN B performed hand hygiene during Resident #2 and Resident #3's wound care. 2. The facility failed to ensure MA E sanitized the blood pressure cuff between use for Resident #4, Resident #5, and Resident #6. 3. The facility failed to ensure CNA F changed her gloves and performed hand hygiene while providing incontinent care to Resident #7. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1.Review of Resident #2's Face Sheet, dated 09/11/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included muscle weakness and diabetes mellitus (body has higher sugar level) without complication. Review of Resident #2 Comprehensive MDS Assessment, dated 08/25/2024, reflected Resident #2 had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated that Resident #2 was at risk of developing pressure ulcer. Review of Resident #2's Comprehensive Care Plan, dated 08/20/2024, reflected the resident was at risk for/actual skin breakdown and one of the interventions was to do treatments and dressing as ordered per physician. Review of Resident #2's Physician Order, dated 09/05/2024, reflected Cleanse Wound every am shift (6am-2pm) on coccyx (tailbone) with NS. Pat dry. Apply collagen powder and cover with dry dressing. Observation on 09/10/2024 at 12:54 PM revealed RN B washed her hands and put on a gown and gloves. RN B positioned herself on the right side of the resident. RN B placed the resident's overbed table on her right her. On the table were wound cleanser, gauze, border dressings, collagen powder, and some gloves. There was no hand sanitizer on the table. RN B removed the old dressing dated 09/09/2024, threw it in the trash can, and took off her gloves. RN B put on a new pair of gloves. She did not sanitize her hands before putting on the new pair of gloves. RN sprayed wound cleanser into a couple of gauze and started to clean the wound from inside to outside. She did it twice. After cleaning the wound with a wound cleanser, she pat dried the wound, applied the collagen powder, and covered it with a border dressing. RN B cleaned-up the table and then washed her hands. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baybrooke Village Care and Rehab Center	8300 Eldorado Parkway West McKinney, TX 75070

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #3's Face Sheet, dated 09/11/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #3's relevant diagnoses included weakness and transient cerebral ischemic attack (insufficient amount of blood flow to the brain). Review of Resident #3's Comprehensive MDS Assessment, dated 07/03/2024, reflected Resident #3 had a severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated Resident #3 was at risk of developing pressure ulcer. Review of Resident #3's Comprehensive Care Plan, dated 08/28/2024, reflected the resident was at risk for/actual skin breakdown related to history of cardiovascular (relating to the heart and blood vessels) disease and one of the interventions was to do treatments and dressing as ordered per physician. Review of Resident #3's Physician Order, dated 07/01/2024, reflected Cleanse Wound every am shift (6am-2pm) cleanse wound to back w/ns, apply Santyl, calcium alginate, cover with border gauze. daily. Observation on 09/11/2024 at 8:51 AM revealed RN B washed her hands and put on a gown and gloves. RN B positioned herself on the right side of the resident. RN B placed the resident's overbed table on her right her. On the table were wound cleanser, gauze, border dressings, Santyl ointment, cotton tip applicator, calcium alginate, and some gloves. There was no hand sanitizer on the table. RN B removed the old dressing dated 09/09/2024, threw it in the trash can, and took off her gloves. RN B put on a new pair of gloves. She did not sanitize her hands before putting on the new pair of gloves. RN B sprayed wound cleanser into a couple of gauze and started to clean the wound from inside to outside. She did it twice. After cleaning the wound with a wound cleanser, she patted dry the wound, applied the Santyl ointment using a cotton tip applicator, applied the calcium alginate, and covered it with a border dressing. RN B cleaned-up the table and then washed her hands. In an interview on 09/11/2024 at 9:26 AM, RN B stated she did change her gloves but did not do hand hygiene in between changing of gloves while doing the wound care. She said she should have sanitized her hands before putting on a new pair of gloves or when changing the gloves to prevent the spread of germs from the hands to the new pair of gloves. She said she would include hand sanitizer on her wound care treatment list to make sure the sanitizer would be on the wound care treatment table every time she would do wound care. 3.Review of Resident #4's Face Sheet, dated 09/11/2024, reflected that the resident was a [AGE] year-old female admitted on [DATE]. Resident #4 was diagnosed with hypertension. Review of Resident #4's Comprehensive MDS Assessment, dated 08/26/2024, reflected that the resident had moderate impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated hypertension as one of Resident #4's active diagnosis. Review of Resident #4's Comprehensive Care Plan, dated 08/22/2024, reflected that the resident had hypertension and interventions were administer medication as ordered and monitor BP every shift. Review of Resident #4's Physician's Order for amlodipine, dated 08/22/2024, reflected losartan 50 mg tablet (LOSARTAN POTASSIUM) 1 tablet by mouth 1 time per day As Needed HIGH BP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/11/2024 at 8:02 AM revealed MA E was preparing Resident #4's medication. MA E sanitized her hands and when her hands were already dry, she picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on Resident #4's arm. After the blood pressure reading was completed, MA E placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #4. She sanitized her hands after giving the medications but did not sanitize the blood pressure cuff after using it. A container of disinfectant wipes was observed on top of the medication cart beside a laptop. MA E then pushed her medication cart and said she would give Resident #5's medication next. 4.Review of Resident 5's Face Sheet, dated 09/11/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #5 was diagnosed with hypertension. Review of Resident #5's Comprehensive MDS Assessment, dated 09/11/2024, reflected resident had moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated hypertension as one of Resident #5's active diagnosis. Review of Resident #5's Comprehensive Care Plan, dated 08/29/2024, reflected resident had hypertension and one of the interventions was administer medication as ordered. Review of Resident #5's Physician's Order for amlodipine, dated 09/04/2023, reflected amlodipine 10 mg tablet (AMLODIPINE BESYLATE) 1 tablet by mouth every morning Hold if Systolic BP Less than 110 Hold if Diastolic BP Less than 60 Hold if Pulse Less than 60. Review of Resident #5's Physician's Order for carvedilol, dated 08/29/2024, reflected carvedilol 6.25 mg tablet (CARVEDILOL) 1 tablet by mouth 2 times per day Hold if Systolic BP Greater than 110 Hold if Diastolic BP Greater than 60 Hold if Pulse Greater than 60. Observation on 09/11/2024 at 8:15 AM revealed MA E started to prepare Resident #5's medication. She said she would check first the resident's blood pressure. She picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #5's arm. After the blood pressure reading was completed, MA E placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #5. She sanitized her hands but did not sanitize the blood pressure cuff after using it. MA E then pushed her medication cart and said she would give Resident #6's medication next. 5.Review of Resident 6's Face Sheet, dated 09/11/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #6 was diagnosed with hypertension. Review of Resident #6's Comprehensive MDS Assessment, dated 09/09/2024, reflected resident had severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated hypertension as one of Resident #6's active diagnosis. Review of Resident #6's Comprehensive Care Plan, dated 08/29/2024, reflected resident had hypertension and one of the interventions was administer medication as ordered. Review of Resident #6's Physician's Order for lisinopril, dated 09/09/2024, reflected lisinopril 10 mg tablet (LISINOPRIL) 1 tablet by mouth 1 time per day Hold if Systolic BP Less than 110 Hold if HR Less than 60. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 09/11/2024 at 8:29 AM revealed MA E started to prepare Resident #6's medication. She said she would check first the resident's blood pressure. She picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #6's arm. After the blood pressure reading was completed, MA E placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #5. She sanitized her hands after giving the medications but did not sanitize the blood pressure cuff after using it. MA E stated she must wash her hands or sanitize her hands before and after administering medications. MA E said hand hygiene was the most effective way to prevent transfer of contamination. MA E said the blood pressure cuff should be sanitized as well after every use for the same reason. She said there was a disinfecting wipe on her medication cart but did not use it to disinfect the wipes after every use. 6.Review of Resident #7's Face Sheet, dated 09/11/2024, reflected that the resident was a [AGE] year-old female admitted on [DATE]. Resident #7 diagnosed with cerebral infarction(blockage in the blood vessels of the brain) and muscle weakness. Review of Resident #7's Comprehensive MDS Assessment, dated 08/04/2024, reflected Resident #7 had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated Resident #7 was always incontinent for bladder and bowel. Review of Resident #7's Comprehensive Care Plan, dated 07/03/2024, reflected that the resident had self-care deficit and one of the interventions was provide assistance with self-care. Observation and interview on 09/11/2024 at 9:13 AM revealed CNA F washed her hands and put on a pair of gloves. CNA F pulled down the blanket then unfastened the tape on both sides of the brief, rolled the front half of the brief, and pushed it between the resident's thighs. CNA F cleaned the front part of Resident #7. CNA F instructed and assisted the resident to roll to her left side. CNA F then proceeded to clean the bottom of the resident. After wiping down the resident, CNA F rolled the rest of the brief, pulled it, and threw it in the trash can. CNA F then got hold of a new brief, opened it, and placed it at the bottom of the resident. CNA F did not change her gloves nor did hand hygiene before touching the new brief. The resident was instructed to roll back. CNA F then fixed the brief, fastened the tape on both sides, fixed the resident's hospital gown, and pulled back the blanket. CNA F stated it was important to wash the hands before and after doing any care for the resident. She stated she did not change her gloves after cleaning the residents' bottom. She said it was important to change gloves after touching soiled items and before touching the clean items to prevent cross contamination. She said she had in-services and check-off about hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/11/2024 at 9:37 AM, the DON stated all the staff should know that hand hygiene was the most effective way to prevent cross contamination and infection. She said, first, the gloves should be changed after touching any soiled items. She said for this case, the gloves should have been changed after cleaning the resident's bottom and after pulling the soiled brief. She stated every time staff changed their gloves, they should do hand hygiene before putting on a new pair of gloves. She said there could be instances that while they were providing care, the staff did not notice the gloves were torn, and the germs could enter the torn gloves and soil the hands. She said, the staff should sanitize the blood pressure cuff after every use. She said not changing the gloves from dirty to clean, not sanitizing the hands in between changing of gloves, and not sanitizing the blood pressure cuff could cause cross contamination. She said the expectation was for the staff to do hand hygiene before and after any care, to change their gloves from dirty to clean, to do hand hygiene in between changing of gloves, and to sanitize the blood pressure cuff after every use. She said she will do an in-service about infection control and hand hygiene immediately after the interview. In an interview with ADON A on 09/11/2024 at 3:14 PM, ADON A stated hand hygiene was included in all the procedures of any care. She said the staff should be mindful in taking care of the residents. She said gloves should be changed after touching the soiled brief, the hands should be washed or sanitized before putting on a new pair of gloves, and the blood pressure should be sanitized after using it. She said all the issues discussed could cause spread of germs and development of infections. She said the expectation was for the staff to do hand hygiene before putting on new gloves, to change their gloves after contact with soiled items, and to sanitize any equipment after using it. ADON A said she would coordinate with the DON on how to go forward with infection control. Review of facility policy, Hand Hygiene for Staff and Residents Infection Control revised August 2018 revealed Purpose: To reduce the spread of infection with proper hand hygiene . Note: Hand hygiene/handwashing is the most important component for preventing the spread of infection . Procedures: 1. Hand hygiene/handwashing is done . Before . A. Before patient/resident contact . After . A. After contact with soiled or contaminated articles such as articles that are contaminated with body fluids . B. After patient/resident contact . H. After removal of medical/surgical or utility gloves . I. Contact with a patient's/resident's intact skin (e.g. taking the pulse or blood pressure . Contact with environmental surfaces in the immediate vicinity of patient/resident. Review of facility policy, Cleaning, Disinfecting, and Sterilizing Resident Care Equipment Infection Control revised August 2018 revealed Policy: Equipment will be maintained and kept sanitized . The rationale for cleaning, sterilizing, and disinfecting resident care equipment is determined by the level of risk of infection . blood pressure cuff and other medical accessories.