

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Baybrooke Village Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 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.  (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:  676096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Baybrooke Village Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure facility staff consulted with resident physician in a timely manner when there was a change in resident's physical, mental, or psychosocial status one (Resident #1) of four residents reviewed for physician notifications. The facility failed to notify Resident #1's physician that he was not provided his medication for epilepsy at any point between [DATE] - [DATE]. This failure placed Resident #1 at risk for adverse effects, injury, and decrease in quality of life. Findings included: Record review of Resident #1's Face Sheet dated [DATE] 10:00 am revealed he was an [AGE] year-old male re-admitted to the facility on [DATE]. Relevant diagnoses included: encephalopathy (brain dysfunction) and epilepsy (abnormal signaling of nerve activity in the brain leading to seizures). Record review of Resident #1's MDS assessment dated [DATE] revealed his cognition was impaired with a BIMS score of 05. He utilized a walker and/or a wheelchair for mobility. He required supervision and/or set-up assistance from facility staff for care. Record review of Resident #1's Physician Orders, dated [DATE], revealed he was prescribed Lamotrigine 250 milligrams, twice a day, for the management of epilepsy. Record review of Resident #1's MAR, dated [DATE] - [DATE], revealed approximately 10 missed scheduled doses of Resident #1's Lamotrigine medication documented between MA C, MA D, and MA E. In interview with the DON on [DATE] 11:02 AM, she stated Resident #1 expired on hospice prior to the time of the investigation. In interview with MA D on [DATE] at 2:18 PM, he stated he provided medications to Resident #1. He stated between [DATE]-[DATE], Resident #1's Lamotrigine medication was not at in the medication cart and not available after looking for the medication, and he promptly reported this to either LVN A or LVN B depending on who was his nurse for that day. He stated it was required to report any deviations to a resident's medication regimen to the resident's nurse for resident health and safety reasons. In interview with MA C on [DATE] at 3:00 PM, she stated she provided medications to Resident #1. She stated between [DATE]-[DATE], Resident #1's Lamotrigine medication was not available to her at this time, and she promptly reported this to either LVN A or LVN B depending on who was his nurse for that day. She stated it was required to report any deviations to a resident's medication regimen to the resident's nurse for resident health and safety reasons. Attempts to interview MA E on [DATE] at 3:15 PM and 4:10 PM were not successful. Attempts to interview LVN A on [DATE] at 9:15 AM and 4:00 PM were not successful. Attempts to interview LVN B on [DATE] at 9:20 AM and 4:20 PM were not successful. In an interview with Resident #1's PHYSICIAN on [DATE] at 11:21 PM, she stated he was prescribed medications for his epilepsy. She further stated medication management was one of his main care objectives while at the facility. She stated consistent administration of his medication was very important to maintain Resident #1's health and quality of life. She stated the facility did not inform her of any disruption in his medications until after it was resolved by the DON. She stated her expectations were for the facility to inform her if Resident #1 missed any of his medications, so she can treat any issues promptly and for general safety reasons. In interview with the DON on [DATE] 11:02 AM, she stated that her expectations were not met with LVN A and LVN B's conduct. She was not notified of Resident #1's Lamotrigine issue until [DATE] and immediately called the pharmacy to address the issue. Additionally, she expected LVN A and LVN B to notify the provider if any resident medications were missed for any reason. She stated this was not done and it was not acceptable. She stated she was not sure why LVN A and LVN B did not escalate this concern up the chain of command, but she terminated both nurses as a result of their actions. She stated the issue with Resident #1's medication was related to an outstanding balance, and the pharmacy was withholding the medication until payment was received. She stated she received corporate approval to resolve the bill quickly so the resident would receive his medications as soon as possible. Additional intervention from the facility included extensive in-services and skills-checkoffs for staff that provide medications to the residents at the facility. She stated it was important for resident safety and to avoid a negative outcome for all residents to receive their prescribed medication in a timely manner. In interview with the Administrator on [DATE] at 3:48 PM, he stated his expectations were not met with LVN A and LVN B's conduct. He stated it was important for nurses to inform the provider if any resident medications were missed for any reason so the provider was aware and could consider appropriate actions and/or alternative options. He stated this was not done and resulted in LVN A and LVN B's termination. Record review of [Pharmacy] Request for Authorization to [NAME] House, dated [DATE] revealed the facility's DON authorized the payment of Resident #1's outstanding balance to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Baybrooke Village Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Baybrooke Village Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure residents received adequate supervision and assistance devices to prevent elopement for one (Resident #1) of six residents reviewed for elopements. The facility failed to ensure Resident #1 remained at the facility where he eloped [DATE] between 11:30 PM and 12:00 AM. Resident #1 was located approximately 0.1 miles away from the facility and returned to the facility by LVN F approximately 12:30 AM on [DATE]. This failure could place residents at risk of injury and a decreased quality of life. Based on record review and interview, the facility failed to ensure residents received adequate supervision and assistance devices to prevent elopement for one (Resident #1) of six residents reviewed for elopements. The facility failed to ensure Resident #1 remained at the facility where he eloped [DATE] between 11:30 PM and 12:00 AM. Resident #1 was located approximately 0.1 miles away from the facility and returned to the facility by LVN F approximately 12:30 AM on [DATE]. This failure could place residents at risk of injury and a decreased quality of life. Findings included: Record review of Resident #1's Face Sheet dated [DATE] 10:00 am revealed he was an [AGE] year-old male re-admitted to the facility on [DATE]. Relevant diagnoses included: encephalopathy (brain dysfunction) and epilepsy (abnormal signaling of nerve activity in the brain leading to seizures). Record review of Resident #1's MDS assessment dated [DATE] revealed his cognition was severely impaired with a BIMS score of 05. He had no documentation of wandering behaviors. Documentation revealed he utilized a walker and a wheelchair for ambulation. He required supervision and/or set-up assistance from facility staff for care. Record review of Resident #1's Elopement Risk assessment, dated [DATE], revealed he was documented as a low risk for wandering and/or elopement. Record review of Resident #1's Pain Assessment after he was returned to the facility, dated [DATE] at 3:36 AM completed by LVN F, it was documented Resident #1 was able to verbalize/communicate his pain and denied any pain at the time of the assessment. In interview with the DON on [DATE] 11:02 AM, she stated Resident #1 expired on hospice prior to the time of the investigation. In an interview with CNA E on [DATE] at 2:28 PM, she stated she was working the night Resident #1 eloped. She stated she rounded on him at midnight and discovered he was not in his bed. She then immediately alerted his nurse, LVN F, and started the facility's elopement protocol. Attempts to interview LVN F at [DATE] at 10:52 AM and [DATE] at 1:48 PM were not successful. In an interview with the DON on [DATE] at 3:30 PM, she stated she expected all residents to remain in the building for safety reasons. She stated she was not exactly sure how Resident #1 eloped from the facility, but he was promptly located next door at [Hospital] by [Hospital Security Guard] and brought back to the facility by LVN F. He was promptly assessed, and no injuries were observed or reported. She stated Resident #1 never displayed wandering behavior and had no previous elopement attempts. She stated as a result of the incident, she did extensive in-services and conducted multiple elopement drills to cover all shifts. She stated it was everyone's responsibility at the facility to ensure residents remained in the building; otherwise injury to the residents could occur. In interview with the Administrator on [DATE] at 3:48 PM, he stated he expected all residents to remain in the building for safety reasons and it was everyone's responsibility at the facility to ensure residents remain in the building. Record review of facility's 1:1 monitoring, dated [DATE] revealed Resident #1 was monitored from 1:00 AM - 12:30 PM by facility staff. Record review of Facility Door Lock Monitor, dated [DATE] revealed facility doorways were checked from [DATE] at 1:00 AM to [DATE] at 5:30 AM. Record review of facility Wander Drill, dated [DATE] at 1:41 PM revealed documentation of a facility-wide elopement drill. Record review of facility Wander Drill, dated [DATE] at 10:45 AM revealed documentation of a facility-wide elopement drill. Record review of facility Wander Drill, dated [DATE] at 3:40 PM revealed documentation of a facility-wide elopement drill. Record review of facility Wander Drill, dated [DATE] at 11:45 PM revealed documentation of a facility-wide elopement drill. Record review of facility's QAPI documentation, dated [DATE], revealed Resident #1's elopement discussed with PHYSICIAN, Administrator, AND DON, Record review of Training In-Service Form, dated [DATE] between 1:41 PM and 1:56 PM, titled Elopement Drill and Policy/Procedure Education, revealed multiple signatures including staff from administrative, therapy, dietary, housekeeping, and nursing departments. Education provided included:-Charge nurse role -Where to look for missing residents-Who to inform once a resident is missing-Once resident is located, nurse completes a head-to-toe assessment-To initiate incident report if not found after 30 minutes Record review of Training In-Service Form, dated [DATE] titled Elopement Procedures, revealed multiple signatures including staff from</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Baybrooke Village Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Baybrooke Village Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that residents are free from significant medication errors for one (Resident #1) of 5 residents reviewed for significant medication errors. The facility failed to ensure Resident #1 received his prescribed seizure medication between [DATE] and [DATE]. This failure placed Resident #1 at risk for adverse effects, injury, and decrease in quality of life. Findings included: Record review of Resident #1's Face Sheet dated [DATE] 10:00 am revealed he was an [AGE] year-old male re-admitted to the facility on [DATE]. Relevant diagnoses included: encephalopathy (brain dysfunction) and epilepsy (abnormal signaling of nerve activity in the brain leading to seizures). Record review of Resident #1's MDS dated [DATE] revealed he was severely cognitively impaired with a BIMS score of 05. He utilized a walker and/or a wheelchair for mobility. He required supervision and/or set-up assistance from facility staff for cares. Record review of Resident #1's Physician Orders, dated [DATE], revealed he was prescribed Lamotrigine 250 milligrams, twice a day, for the management of epilepsy. Record review of Resident #1's MAR, dated [DATE] - [DATE], revealed approximately 10 missed scheduled doses of Resident #1's Lamotrigine medication documented between MA C, MA D, and MA E. In interview with the DON on [DATE] 11:02 AM, she stated Resident #1 expired on hospice prior to the time of the investigation. In interview with MA D on [DATE] at 2:18 PM, he stated he provided medications to Resident #1. He stated between [DATE]-[DATE], Resident #1's Lamotrigine medication was not available and he promptly reported this to either LVN A or LVN B depending on who was his nurse for that day. He stated it was required to report any deviations to a resident's medication regimen to the resident's nurse for resident health and safety reasons. In interview with MA C on [DATE] at 3:00 PM, she stated she provided medications to Resident #1. She stated between [DATE]-[DATE], Resident #1's Lamotrigine medication was not available and she promptly reported this to either LVN A or LVN B depending on who was his nurse for that day. She stated it was required to report any deviations to a resident's medication regimen to the resident's nurse for resident health and safety reasons. Attempts to interview MA E on [DATE] at 3:15 PM and 4:10 PM was not successful. Attempts to interview LVN A on [DATE] at 9:15 AM and 4:00 PM were not successful. Attempts to interview LVN B on [DATE] at 9:20 AM and 4:20 PM were not successful. In an interview with Resident #1's Physician on [DATE] at 11:21 PM, she stated he was prescribed medications for his epilepsy. She further stated medication management was one of his main care objectives while at the facility. She stated consistent administration of his medication was very important to maintain Resident #1's health and quality of life. She stated the facility did not inform her of any disruption in his medications until after it was resolved by the DON. She stated her expectations were for the facility to inform her if Resident #1 missed any of his medications, so she can treat any issues promptly and for general safety reasons. In interview with DON on [DATE] 11:02 AM, she stated that her expectations were not met with LVN A and LVN B's conduct. She was not notified of Resident #1's Lamotrigine issue until [DATE], and immediately called the pharmacy to address the issue. Additionally, she expected the staff to notify the provider if any resident medications were missed for any reason. She stated this was not done and was not acceptable. She stated she was not sure why LVN A and LVN B did not escalate this concern up the chain of command, but she terminated both nurses as a result of their actions. She stated the issue was related to an outstanding balance, and the pharmacy was withholding the medication until payment was received. She stated she received corporate approval to resolve the bill quickly so the resident would receive his medications as soon as possible. Additional intervention from the facility included extensive in-services and skills-checkoffs for any staff that provided medications to the residents at the facility. She stated it was important for resident safety and to avoid a negative outcome for all residents to receive their prescribed medication in a timely manner. In interview with Administrator on [DATE] at 3:48 PM, he stated his expectations were not met with LVN A and LVN B's conduct. He stated it was important for nurses to inform the provider if any resident medications were missed for any reason so the provider was aware and could consider appropriate actions and/or alternative options. He stated his was not done and resulted in LVN A and LVN B's termination. Record review of [Pharmacy] Request for Authorization to [NAME] House, dated [DATE], revealed the facility's DON authorized the payment of Resident #1's outstanding balance to [Pharmacy]. Record review of Training In-Service Form, dated [DATE] titled Resident Rights, Abuse + Neglect, and Medication Administration and Documentation, Notification to DON/Designee and MD When MD Not Available conducted by facility DON revealed multiple</p>		