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	03/05/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Residents #1) of 1 resident reviewed for quality of care.The facility failed to ensure Resident #1's Stage 4 pressure ulcer on his sacrum was covered with a dressing on 03/05/26.This failure could place residents at risk of severe pain, and lead to systemic infections causing harm for residents.Findings included:1.Record review of Resident #1's entry MDS Assessment, dated 02/02/26, reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. The resident had severe cognitive impairment with a BIMS score of 4, and his diagnoses included diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar (hyperglycemia) due to insufficient insulin production (Type 1) or ineffective insulin use (Type 2 and the MDS reflected he had a Stage 4 pressure ulcers that was present upon admission/entry.Record review of Resident #1's care plan, dated 02/23/26, reflected: Problem: [Resident #1] has Stage 4 pressure ulcer of sacral. Goals: Pressure ulcers will show signs of healing and be free from infection. Interventions: - Treatment as ordered, monitor and report if ineffective.Record review of Resident #1's Physician orders, dated 02/20/26, reflected: - Cleanse sacrum and bilateral buttock stage 4 with wound cleanser, pat dry, apply Santyl and calcium alginate cover with dry dressing dailyRecord review of Resident #1's Progress Notes for March 2026 reflected there was no information related to his wound dressing not being there on 03/05/26.Review of treatment administration record on 03/05/26 revealed treatment was last administered on 03/03/26 before treatment was changed to Tuesday, Thursday and Saturday on 03/04/26. Observation and interview on 03/05/26 at 01:55PM revealed Resident #1 was lying in bed. Resident#1 stated he was doing well. Resident#1 stated he admitted to the facility with wounds on his sacrum. Observation on 03/05/26 at 02:02PM revealed CNA B was providing Resident #1 with incontinence care. She sanitized and put on Personal protective equipment (PPE) and explained the procedure to resident. She put all supplies together, washed her hands, and put on gloves. CNA B cleansed the resident's abdominal folds and the perineal using one wet wipe. She helped the resident to turn using the draw sheet. She cleansed the resident's buttocks. Resident was observed to have an open wound on his sacrum that was not covered and draining on the brief. She removed gloves washed hands, put on clean gloves, applied a clean brief, and left resident comfortable. She removed the PPE and washed her hands.Interview on 03/05/26 at 02:10 PM with CNA B revealed she was the CNA assigned to Resident #1. She stated she had provided incontinence care to Resident #1. She stated she noticed the resident's dressing was peeling off, and it had fecal matter on it, so she removed the dressing at 09 :30 AM. She stated she knew she was supposed to notify the nurse or the treatment nurse about the soiled dressing, which fell off, but she did not. She stated it slipped her mind, and she forgot to notify the nurse. She stated she was aware she was not allowed to remove dressings, and she knew she was supposed to call the nurse to come and replace the soiled and peeling dressing with clean dressing, but not for her to remove it. She stated Resident #1 did not complain of pain. She stated the risk of not having a dressing on would be infection and the wound getting bigger. She stated she had (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
	676096	A. Building B. Wing	03/05/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done training on calling the nurse if a dressing had become soiled and not to remove the dressing, but she could not recall when. Interview on 03/05/26 at 03:31PM with RN C, who was the charge nurse assigned to Resident#1, revealed she was not made aware that Resident #1's dressing had come off by CAN B while she provided incontinent care earlier that morning. She stated her expectation was for CNA B to report to her so that she could replace the soiled dressing with a clean dressing when she was performing incontinent care on Resident #1. She stated the risk of removing a dressing and not replacing it with a clean one, was infection. She stated she had done training on dressing changes, if soiled or dislodged but she could not tell when it was.Interview on 03/05/26 at 04:23PM with the Wound Care Nurse revealed Resident #1 had a physician's order to cleanse and cover the wound daily and an order for as needed in case the dressing got soiled or dislodged. She stated she was not made aware that Resident #1's dressing had come off. She stated when she completed wound care (03/03/26) on Resident #1, she had applied a dressing over it. She stated her expectations were for the nurses to monitor the dressing every shift and if the dressing came off, the resident had as needed treatment orders to follow. She stated her expectation was for CNA B to call her or the nurse to replace the soiled or dislodged dressing. She stated the potential risk of dressing falling off would be wound decline and infections. She stated she preferred the CNAs to notify the nurses, because if the wound was left open, the resident could have a bowel movement and that also would predispose Resident#1 to the risk of infection. She stated she had not provided staff with training since she was newly employed.Interview on 03/05/26 at 04:40 PM with the Regional Nurse Coordinator revealed Resident #1 should have had a dressing on his sacrum wound. The Regional Nurse Coordinator said all wound dressing orders was scheduled and PRN orders so that if the dressing were soiled during incontinent care, it could be replaced by the nurse on duty. The Regional Nurse Coordinator said the nurse on duty would have been responsible for replacing the dressing when CNA B noticed it was missing or soiled. The Regional Nurse Coordinator said the facility had trained staff on wound care and dressing changes, but no training records were provided as requested during the interview. Record review of the facility's treatment of wounds: dressing changes- performing (general information policy, dated July 2018, reflected: 8. Change the wound dressing if feces seep beneath the dressing

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	03/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 2 (Resident #1 and Resident#2) of 4 residents reviewed for quality of care.1. The facility failed to ensure Residents #1 was being provided with oxygen on 03/05/26 at 02:02PM as per physician's orders. 2.The facility failed to ensure Resident #2 had physician's order in her chart for oxygen that was observed being provided on 03/05/26. This failure could place residents at risk of illness and respiratory complications.Findings included:1.Record review of Resident #1's entry MDS Assessment, dated 02/02/26, reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. The resident had severe cognitive impairment with a BIMS score of 4, and his diagnoses included Shortness of breath, and he was on continuous oxygen therapy.Record review of Resident #1's care plan dated 01/31/2026 reflected: Problem [Resident#1] Respiratory Diagnosis. Goals: Improve or maintain respiratory status. Interventions: Administer Oxygen as orderedRecord review of Resident #1's active physician's orders dated 02/01/20256 revealed oxygen at 2 LPM by NC every Shift for shortness of breath.Observation on 03/05/26 at 02:02PM revealed Resident #1 was lying in bed and not receiving oxygen. The tubing was observed covered with bedsheets and the oxygen concentrator was marked at 2 liters per minute and was actively running. The only staff that was near the resident was CNA B who was being observed for incontinent care.Observation and interview on 03/05/26 at 02:24PM with CNA B inside Resident#1 room revealed the tubing was covered with his bedsheets. CNA B stated she had not noticed he was not on oxygen, and Resident #1 was known for removing his canula from his nose, but she had not reported that to the nurse. She stated she knew he was supposed to be on continuous oxygen at 2 liters (of supplemental oxygen every minute.Interview on 03/05/26 at 03:31 PM with RN C revealed she was the nurse assigned to Resident #1. She stated Resident #1 had oxygen orders for continuous oxygen. She stated she was not aware he was not on oxygen, and she had not been to his room for hours. She stated it was nurses' responsibility to be checking on residents on oxygen to ensure they were getting oxygen. She stated the possible negative outcome for not receiving oxygen could be difficulty breathing.2. Record review of Resident #2's admission MDS assessment, dated 02/10/2026, indicated Resident #2 was an [AGE] year-old female, who originally admitted to the facility on [DATE] and readmitted on [DATE]. The assessment indicated Resident #2's BIMS score was 10, which indicated her cognition was moderately impaired. The assessment indicated Resident #2 had chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) and acute respiratory failure with hypoxia (condition where the body's tissues don't get enough oxygen to function properly) Record review of Resident #2 care plan, dated,1/22/26 indicated Problem: - Respiratory Diagnosis. Goal: Improve or maintain respiratory status. Interventions Administer Oxygen as ordered.Record review of Resident #88's physician order summary report, dated 03/05/26, did not indicate an active physician's order for oxygen use. Observation and interview on 03/05/26 at 12:30 PM revealed, Resident #2 was with a family member in the dining room with portable oxygen tank at zero liters per minute and the tubing was not connected on her. Interview with Resident#2 revealed she was on oxygen, and she received oxygen when provided by nurses. The family member stated she could not recall her mother on oxygen, and she came to visit her almost every day during lunch time.Observation on 03/05/26 at 01:43 PM revealed Resident#2 was on oxygen at 2 liters per minute.Interview and observation on 03/05/26 at 01:45PM PM with RN C revealed Resident #2 was on oxygen at 2 liters per minute, and she could not recall whether there was an order in her chart. She stated she did not see an order for Resident #2's oxygen use. RN C stated, there should be an order for oxygen, and Resident #2 should not be given oxygen without one. RN C stated nurses were responsible for ensuring resident orders were in chart and should match care provided. RN C stated she was the one that put residents on portable oxygen (continued on next page)

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	03/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before leaving the room for therapy in the morning. RN C stated not having an order for oxygen placed Resident #2 at risk of further respiratory concerns and shortness of breath. Interview on 03/05/26 at 04:40PM with the [NAME] Nurse Coordinator revealed residents who received oxygen should have oxygen orders. She stated it was the responsibility of the charge nurse, or whoever applied oxygen, to ensure physician orders were obtained and put in the resident's chart. She stated the risk of administering oxygen without orders would be very low risk depending on resident status. The Regional Nurse Coordinator stated that all nurses were responsible for monitoring and evaluating residents on oxygen and administer oxygen. She stated the risk of not administering oxygen would be oxygen levels could drop, altered mental status, heart attacks, and a resident could go into distress.Record review of the facility's policy titled Oxygen Administration and dated October 2010 revealed the following: . 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess any special needs of the resident.Record review of the facility's policy titled OXYGEN THERAPY, CONCENTRATOR - INITIATION revised January 12,2020 revealed the following: The licensed staff will provide the prescribed amount of oxygen therapy to the residents as prescribed by physician and according to practice guidelines.1. Review physicians' order for oxygen.13. Document in the eMAR/eTAR ordered oxygen therapy administration.