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	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baybrooke Village Care and Rehab Center	8300 Eldorado Pkwy 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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have physician orders for the resident's immediate care, at the time the resident was admitted for 1 of 5 residents (Resident #1) reviewed for admission orders.The facility failed to have Physician orders to provide wound care for Resident #1 who admitted on [DATE] until 2 days later on [DATE].This failure could place the residents at risk of not receiving necessary physician ordered care that could result in worsening conditions or decline in health. Findings included:Record review of Resident #1's face sheet, dated [DATE], revealed an [AGE] year-old male admitted on [DATE] with a diagnosis of Malignant Neoplasm of thyroid gland (thyroid cancer). Record review of Resident #1's discharge MDS, dated [DATE], revealed that he expired in the facility on [DATE]. Record review of Resident #1's care plan , dated [DATE], revealed that he required a 1-2-person assistance with ADLs, and a 2-person assistance transfer with a mechanical lift due to his malignant neoplasm of thyroid gland. Resident #1's care plan further revealed that he was at risk of pain related to cancer.Record review of Resident #1's admission Skin Assessment completed by the Wound Care Nurse, dated [DATE], revealed that he had a tumor wound on his neck. Record review of Resident #1's progress note, completed on [DATE] at 6:12 PM from ADON B revealed the following, Resident arrived via [Transport company]. Resident [sic] vitals are stable. 123/78 BP 97.7 T, 79P, 98 O2. Resident DX thyroid cancer. Resident lungs are clear. BS are present. Turgor good. Skin intact. PRN O2 at 2-4 liters. Resident is on a liquid diet and uses straw. Residents' family present. Teaching provided on neck. Do not get up out of bed, do not get dressed, resident will stay in hospital gown per request of family. Care to neck provided multiple times throughout the day depending on amount of blood noted. Resident is a hospice pt. [Hospice Company]Record review of Resident #1's progress note, completed on [DATE] at 10:52 PM by LVN A revealed the following, Wound dressing changes per family. MD notifiedRecord review of Resident #1's progress note, completed on [DATE] at 1:24 PM by LVN A revealed the following, Taking care of patient, [AGE] year old thyroid cancer patient. Family has a procedure on how they want the wound done. I wrote down the steps and texted it to [Facility MD]. Hospice Nurse has been here twice but does not have any wound orders. One of the Nurses even told me that they don't do wounds. However, the family insisted that the wound care be performed at least 2x daily. I spoke to [Facility MD] and she asked me to call the hospice to confirm the order. I called the hospice and they said they are still working on the Order.Record review of Resident #1's physician orders, dated [DATE], revealed the following, ([START [DATE] [2:45 PM] Information Only.Wound care orders as follows' [Hospice Company]. Cleanse area with normal saline, pat dry, apply bleed stop powder to area of wound, cover with dry dressing . Change dressing daily or PRN as needed if soiled. During an interview on [DATE] at 2:21 PM with Resident #1's Family Member revealed she brought Resident #1 to the facility because he was getting closer to the end, was on hospice services, and required full time care. She stated when they brought Resident #1 to the facility on [DATE], she educated the staff and wound care nurse on how to care for Resident #1's tumor wound. The Family Member stated Resident #1 had thyroid cancer that was protruding through the skin. She stated the wound care provided at home required a powder to stop the bleeding and was the only thing that was effective. The Family Member (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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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the Wound Care Nurse did not complete Resident #1's wound care that she was aware of. The Family Member stated herself, the weekend hospice nurse, or the floor nurses at the facility did the wound care. The Family Member stated hospice provided the facility with the wound care orders when Resident #1 admitted but it was not completed the proper way unless she was at the facility. During an interview on [DATE] at 12:22 PM, the Wound Care Nurse revealed she worked at the facility since 2007. The Wound Care nurse stated Resident #1 admitted on a Friday and she saw him the following Monday, [DATE]. She stated she did his wound care 1 or 2 times. The Wound Care Nurse stated she updated the wound care order on Monday and Tuesday because the family wanted it done differently. The Wound Care Nurse stated she contacted the Facility MD and updated the wound care orders according to the family member's request. The Wound Care Nurse stated the floor nurses did the wound care on the weekends because she was not at the facility. The Wound Care Nurse stated she never saw the tumor bleeding, but that the Family Member would not allow staff to clean it, so they applied a powder to it. She stated she was not aware that there were no wound care orders at the time of admission. The Wound Care Nurse stated hospice should have provided the order at the time of admission, but the facility MD could have been contacted for one, if not. She stated the risk of not having a wound care order at the time of admission was an infection risk. During an interview [DATE] at 12:50 PM, the Hospice Nurse revealed she was the nurse who admitted Resident #1 to the facility on [DATE]. She stated Resident #1 was admitted on a Friday ([DATE]) then passed away the following Tuesday ([DATE]). The Hospice Nurse stated she provided the facility with written orders on [DATE] that included wound care orders. She stated there was a daily and a PRN order if it was soiled. The Hospice Nurse stated the wound care order was updated on Monday ([DATE]) or Tuesday ([DATE]) to 3 times a day due to it bleeding.During an interview on [DATE] at 1:18 PM, LVN A revealed she worked at the facility PRN since [DATE]. She stated Resident #1 was admitted to the facility with hospice services. LVN A stated she completed the wound care on Resident #1 twice a day. LVN A stated she called hospice because the wound care the Family Member wanted was not in their system. LVN A stated she was not there when Resident #1 admitted , but that the hospice must not have provided them with wound care orders. LVN A stated Hospice wound not give the wound care orders and she had to pressure them to finally give the orders, and that was when she put them in their system. She stated she could not recall the specific dates. LVN A stated she notified the Facility MD on [DATE] before hospice provided the order and the MD told her to confirm the order with hospice. She stated she did not notify the Facility MD about hospice not providing the wound care order. LVN A stated there should have been an order for wound care, but that the Family Member was present teaching her how to do it. LVN A stated the risk of not having a wound care order was not providing proper care. During an interview on [DATE] at 4:22 PM, the ADON B revealed she worked at the facility for 4 months. ADON B stated she was working the floor when Resident #1 admitted to the facility on [DATE]. ADON B stated she recalled pulling the Wound Care Nurse into Resident #1's room to complete the wound care and to get orders from hospice. ADON B stated she did not recall getting wound care orders from hospice initially, but the Family Member wanted the wound care completed according to her steps. ADON B stated she was not sure why the wound care orders were not put in their system until [DATE]. ADON B stated she did not provide the wound care for Resident #1, but that she observed the Family Member completing it when the resident first got to the facility. ADON B stated the nurses were responsible for ensuring all orders were in place when Resident #1 was admitted to the facility. She stated the staff should not have performed wound care without physician orders. ADON B stated if Hospice did not provide a wound care order, the Facility MD or Wound Dr. should have provided a temporary order. ADON B stated the risk of completing wound care without an order was injuring the resident. During an interview on [DATE] at 6:06 PM, the DON revealed she worked at the facility for 2 months. The DON stated dressing changes were completed a couple times a day on Resident #1 due to his large cancer tumor. The DON stated she was aware they had to contact Hospice about updating the orders due to Resident #1's family requests. The DON (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was not aware that no wound care orders were put in place when he admitted to the facility. She stated if hospice did not provide an order, she expected the nursing staff to notify the facility's MD to get wound care orders until hospice provided them. The DON stated the risk of not having wound care orders was infection. She stated it was the whole nursing team's responsibility to ensure the orders were completed. During an attempted telephone interview on [DATE] at 1:45 PM, the Facility Physician did not answer and no phone call was returned during the investigation. During an interview on [DATE] at 6:39 PM, the Administrator revealed he had worked at the facility since [DATE]. He stated Resident #1 admitted to the facility with the tumor. The Administrator stated he expected there to be wound care orders for any wound care. He stated the risk of not having those orders was it affected the plan of care and that Resident #1 required frequent wound dressing changes. The Administrator stated dressing changes needed to be completed based on physician orders. Record review of the facility's policy titled, Physician Orders, revised [DATE], revealed the following: .2. The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care plan and provide a summary of their baseline care plan to residents for 1 of 5 residents (Resident #1) reviewed for care plans.The facility failed to complete a baseline care plan that addressed hospice services for Resident #1. This failure could place residents at risk of not being provided with the necessary care and having personalized plans developed to address their specific needs.Findings included :Record review of Resident #1's face sheet, dated [DATE], revealed he was an [AGE] year-old male who admitted on [DATE] with a diagnosis of Malignant Neoplasm of thyroid gland (thyroid cancer). Record review of Resident #1's discharge MDS, dated [DATE], revealed that he expired in the facility on [DATE]. Record review of Resident #1's care plan, dated [DATE], revealed that he required a 1-2-person assistance with ADLs, and a 2-person assistance transfer with a mechanical lift due to his malignant neoplasm of thyroid gland. Resident #1's care plan further revealed that he was at risk of pain related to cancer and was a DNR. Record review revealed no care plan for hospice services. Record review of Resident #1's progress note, completed on [DATE] at 6:12 PM from ADON B revealed the following, Resident arrived via [Transport company]. Resident vitals are stable. Resident DX thyroid cancer.Resident is a hospice pt. [Hospice Company]Record review of Resident #1's physician orders, dated [DATE], revealed the following order effective [DATE], Admit to Skilled Care.for Malignant neoplasm of thyroid gland. Record review revealed no physician order for hospice care services. Interview on [DATE] at 12:50 PM with the Hospice Nurse revealed she was Resident #1's case manager. She stated she was unable to recall how long he was on hospice services due to him having a different nurse while he lived at home. The Hospice Nurse stated he was admitted to the facility on hospice services, and she provided the facility with written orders, but that his records were also faxed over before he admitted . Interview on [DATE] at 4:22 PM with ADON B revealed she had worked at the facility for 4 months. ADON B stated she was working the floor when Resident #1 was admitted to the facility on hospice services on [DATE]. She stated Resident #1's care plan should have included hospice services with the company name. She stated it was the nurse's responsibility to include that as part of the care plan. She stated the risk of not having hospice on the care plan was it could cause harm to the resident.Interview on [DATE] at 6:06 PM with the DON revealed she had worked at the facility for 2 months. The DON stated Resident #1 should have had a care plan for hospice. She stated it was the whole nursing team's responsibility to review and complete the care plans. The DON stated the risk of not having hospice on the care plan was it could affect Resident #1's quality of care. Record review of the facility's policy titled, Hospice Program revised [DATE], revealed the following: .2. When a resident participates in the hospice program, a coordinated plan of care between the community, hospice agency and resident/family will be developed and shall include but not limited to directives for managing pain and other uncomfortable symptoms. The care plan shall be revised by the Interdisciplinary Team, as necessary to reflect the resident's current status.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to order and administer Levothyroxine (Levothyroxine Sodium) for Resident #1 while at the facility from 05/01-[DATE]. This failure could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings included:Record review of Resident #1's face sheet, dated [DATE], revealed he was an [AGE] year-old male who admitted on [DATE] with a diagnosis of Malignant Neoplasm of thyroid gland (thyroid cancer). Record review of Resident #1's discharge MDS, dated [DATE], revealed that he expired in the facility on [DATE]. Record review of Resident #1's care plan, dated [DATE], revealed that he required a 1-2-person assistance with ADLs, and a 2-person assistance transfer with a mechanical lift due to his malignant neoplasm of thyroid gland. Resident #1's care plan further revealed that he was at risk of pain related to cancer.Record review of Resident #1's medication list, faxed to the facility from the hospice company on [DATE] at 2:51 PM revealed the following order: Levothyroxine 112 mcg (medication to treat underactive thyroid) oral tablet every day with a start date of [DATE]. Record review of Resident #1 facility physician orders, undated, revealed the following order: LEVOTHYROXINE 112 MCG TABLET (Levothyroxine Sodium) Malignant neoplasm of thyroid gland for Diagnostic ([START [DATE] 13:31] 1 tab by mouth One time daily [Time: 08:00 AM])Record review of Resident #1's May MAR, undated, revealed no doses of the levothyroxine were administered while at the facility . During an interview on [DATE] at 2:21 PM with Resident #1's Family Member revealed she took Resident #1's thyroid medication to the facility with the rest of his medications when he arrived on [DATE]. She stated Resident #1 never received his thyroid medication while he was there because she asked a nurse about it before he died and she was not aware of it. The Family Member stated she confirmed when she received the medications back after he passed that the levothyroxine was never given to him. The Family Member stated he was taking it at home on hospice, and it was present on his medication list. During an interview on [DATE] at 12:50 PM, the Hospice Nurse revealed she was the nurse who admitted Resident #1 to the facility on [DATE]. She stated he was admitted on a Friday ([DATE]) then passed away the following Tuesday ([DATE]). The Hospice Nurse stated she provided the facility with written orders on [DATE]. She stated she recalled writing an order for the Levothyroxine since it was on his medication list. During an interview on [DATE] at 3:52 PM, RN C stated she recalled the Family Member asking her about his levothyroxine. She stated she contacted the MD and got an order for it. RN C stated she saw it was on his previous medication list and Resident #1 should have received it while at the facility. She stated she did not give him the levothyroxine and was unable to recall if it was in the medication cart. RN C stated the risk of residents not receiving their medications was they would not get the medication benefits. RN C stated it was the nurse who admitted Resident #1's responsibility to put the orders in, but all nurses could review and check. During an interview on [DATE] at 4:22 PM, ADON B revealed she had worked at the facility for 4 months. ADON B stated when hospice provided a medication list or written orders, it should get uploaded into the MAR by the facility nurse. ADON B stated there should have been an order for Levothyroxine if it was on Resident #1's medication list. ADON B stated she was the one who uploaded his medications into the MAR when he admitted but could not recall any of the medications or orders. She stated all the nurses were responsible for ensuring the orders were updated and accurate. The ADON stated the risk of not having all the medications put in the MAR, was it would not be administered, and could cause harm to the resident. During an interview on [DATE] at 6:06 PM, the DON revealed she had worked at the facility for 2 months. The DON stated Resident #1's levothyroxine should have been ordered on admission if it was on his medication list. The DON was unable to confirm why the medication was not added until [DATE]. The DON stated the risk of not having the medication ordered was it affected (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents' quality of care and disease management. She stated it was the whole nursing team's responsibility to ensure the orders were completed.During an attempted telephone interview on [DATE] at 1:45 PM, the Facility Physician did not answer and no phone call was returned during the investigation. Record review of the facility's Physician Orders, revised [DATE], revealed the following: .2. The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician.Record review of the facility's Hospice Program policy, revised [DATE], revealed the following: .6. The Hospice Agency will provide the following documentation:.g. Hospice physician and attending physician (if any) orders specific to the resident.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care for 1 of 4 residents (Resident #1) reviewed for hospice services. The facility failed to ensure Resident #1 had a physician order for hospice care. This failure could place residents at risk of receiving inadequate end-of-life care, coordination of care and communication of resident needs. Findings included : Record review of Resident #1's face sheet, dated [DATE], revealed he was an [AGE] year-old male who admitted on [DATE] with a diagnosis of Malignant Neoplasm of thyroid gland (thyroid cancer). Record review of Resident #1's discharge MDS, dated [DATE], revealed that he expired in the facility on [DATE]. Record review of Resident #1's care plan, dated [DATE], revealed that he required a 1-2-person assistance with ADLs, and a 2-person assistance transfer with a mechanical lift due to his malignant neoplasm of thyroid gland. Resident #1's care plan further revealed that he was at risk of pain related to cancer and was a DNR. Record review revealed no care plan for hospice services. Record review of Resident #1's progress note, completed on [DATE] at 6:12 PM from ADON B revealed the following, Resident arrived via [Transport company]. Residet vitals are stable. Resident DX thyroid cancer.Resident is a hospice pt. [Hospice Company]Record review of Resident #1's physician orders, dated [DATE], revealed the following order effective [DATE], Admit to Skilled Care.for Malignant neoplasm of thyroid gland. Record review of Resident #1's physician orders, dated [DATE], revealed no physician order for hospice care services. During an interview on [DATE] at 2:21 PM, Resident #1's Family Member revealed she brought Resident #1 to the facility because he was getting closer to the end, was on hospice services, and required full time care. The Family Member stated Resident #1 was on hospice services when he lived at home and it was continued once at the facility. During an interview on [DATE] at 12:50 PM, the Hospice Nurse revealed she was Resident #1's case manager. She stated she was unable to recall how long he was on hospice services due to him having a different nurse while he lived at home. The Hospice Nurse stated he was admitted to the facility on hospice services, and she provided the facility with written orders, but that his records were also faxed over before he admitted . During an interview and observation on [DATE] at 4:22 PM, ADON B revealed she had worked at the facility for 4 months. ADON B stated she was working the floor when Resident #1 admitted to the facility on [DATE]. ADON B stated Resident #1 was admitted to the facility on hospice services. She stated there should have been an admit to hospice order in Resident #1 physician orders. During the interview, ADON B reviewed the physician orders and stated there was no admit to hospice order. ADON B stated she recalled putting in a progress note that Resident #1 was on hospice services, but could not recall why the order was not put in. ADON B stated the risk of not having a hospice order was harm to the patient . ADON B stated it was all the nurse's responsibility to ensure the hospice order was put in. During an interview on [DATE] at 6:06 PM, the DON revealed she had worked at the facility for 2 months. The DON stated Resident #1 should have had an admit to hospice order since he admitted to the facility on hospice services. The DON stated the hospice order was to notify staff and assist with Resident #1's quality of care. The DON stated the order also reminded staff to review the hospice binder for continuity of care. The DON stated it was the whole nursing team's responsibility to ensure the orders were complete. She stated the risk of not having a hospice order affected the quality of care. Record review of the facility's policy titled, Hospice Program revised [DATE], revealed the following: .2. When a resident participates in the hospice program, a coordinated plan of care between the community, hospice agency and resident/family will be developed and shall include but not limited to (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directives for managing pain and other uncomfortable symptoms. The care plan shall be revised by the Interdisciplinary Team, as necessary to reflect the resident's current status.7. Documentation will be housed in the electronic health record (EHR) under the Hospice tab If the hospice agency has their own proprietary EHR, the facility will scan and upload documentation into the communities' EHR.