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	06/17/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident has a right to personal privacy and confidentiality of his or her personal and medical records for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility failed to ensure that Resident #1's personal information was kept private and confidential when a pre-filled affidavit of heirship containing the resident's information was sent to the family of Resident #2. This failure could place residents at risk of having their sensitive information accessible to unauthorized individuals.Findings included:Record review of Resident #1's admission MDS Assessment, dated [DATE], reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident's cognition was intact with a BIMS score of 15, and her active diagnoses included: chronic obstructive pulmonary disease (lung disease), respiratory failure, and Type 2 diabetes (the body's inability to regulate blood glucose levels). Record review of Resident #1's Discharge MDS Assessment, dated [DATE], reflected the resident expired at the facility on [DATE]. Record review of Resident #1's care plan, revised [DATE], reflected the resident had an advanced directive with a goal to honor and review annually and upon significant change in condition. Interventions included: ensuring the advanced directive was discussed with resident and/or RP and appropriate paperwork obtained. Record review of Resident #2's Discharge MDS Assessment, dated [DATE], reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE] and expired at the facility on [DATE]. Record review of a document provided by Resident #2's RP titled Affidavit of Heirship- [Resident #1], undated, reflected the document was pre-filled with Resident #1's personal information that included in part the following: [Resident #1's RP] (hereafter the Affiant), having been duly sworn, states upon oath:That her [family], [Resident #1], (hereinafter the . Decedent .) died on February 24, 2026.That at the time of her death, the Decedent was domiciled in Texas.That at the time of her death, the Decedent was not married. In an interview on [DATE] at 4:20 p.m., Resident #1's RP stated Resident #1 expired at the facility on [DATE] and the family had to complete an affidavit of heirship to receive the medical records from the facility. Resident #1's RP stated about 2 months later a stranger reached out to her via social media and informed her that she received a document with Resident #1's information on it, and that was how she found Resident #1's RP. Resident #1's RP stated the stranger informed her that she was Resident #2's RP. Resident #1's RP stated although it was kind for Resident #2's RP to reach out, she was concerned that the facility violated HIPAA and was irresponsible with sensitive information. Resident #1's RP stated she was worried about what other information was exposed and who else had it, especially since it was so easy for Resident #2's RP to find her. In an interview on [DATE] at 4:45 p.m., Resident #2's RP stated Resident #2 expired at the facility on [DATE] and the family was also requesting medical records when they received documents with Resident #1's information on it. Resident #2's RP stated the facility's Attorney contacted her and asked that she disregard and destroy the document because it was accidentally sent to her. Resident #2's RP stated the message seemed suspicious and she knew she had to notify Resident #1's RP and the state agency. Resident #2's RP stated this was a HIPAA violation, and she did not want this to happen to other residents. In an interview on [DATE] at 11:00 a.m., the Administrator was asked to provide the (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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy regarding privacy and confidentiality. He stated that the facility followed the HIPAA rules per federal law. In an interview on [DATE] at 1:00 p.m., the Administrator stated to his knowledge, a new affidavit of heirship was created when Resident #2's RP requested medical records. He stated he did not have any additional information to provide and advised the surveyor to speak with the facility's Attorney. In an interview on [DATE] at 1:48 p.m., the facility's Attorney stated he was outside council, and the process for requesting medical records was done at the facility level. The Attorney stated the affidavit of heirship was not prepared at his office, and he had not reviewed it to state whether or not it included information that violated HIPAA. The Attorney stated he reached out to Resident #2's RP and advised her to destroy any documents that were accidentally sent to her with incorrect information. However, he could not confirm what information was included. The Attorney advised the surveyor to speak with the facility's compliance officer to determine if there was a HIPAA violation. An attempted interview on [DATE] at 2:46 p.m. with the Compliance Officer was unsuccessful due to no response to call. This surveyor left callback information on the voicemail. In an interview on [DATE] at 3:45 p.m., the Administrator stated he was made aware that there were two pieces of information on the document sent to Resident #2's RP that violated HIPPA, and that was Resident #1's name and date of death . The Administrator stated violating a resident's privacy and confidentiality could pose the risk of unauthorized parties having knowledge of private information. Review of the U.S. Department of Health and Human Services website, < https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html >, reflected in part the following: .Protected Health Information. The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI).12Individually identifiable health information is information, including demographic data, that relates to:the individual's past, present or future physical or mental health or condition,the provision of health care to the individual, orthe past, present, or future payment for the provision of health care to the individual,and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.13 Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit residents from returning to the facility after a hospitalization for 1 of 3 residents (Resident #3) reviewed for discharge rights. The facility failed to allow Resident #3 to return to the facility after the resident discharged from the hospital. The facility issued Resident #3 a discharge notice on 01/23/26 for non-payment of services rendered; however, the resident appealed the discharge and the discharge was reversed after a fair hearing on 03/26/26. This failure could place residents at risk of not receiving appropriate ongoing care, which could lead to worsening conditions or serious harm.Findings included:Record review of Resident #3's Quarterly MDS Assessment, dated 03/19/26, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had severe cognitive impairment with a BIMS score of 3, and her active diagnoses included: stroke (blood supply to brain blocked or reduced) and Type 2 diabetes (the body's inability to regulate blood glucose levels). Record review of Resident #1's care plan, revised 02/10/26, reflected the resident had an advanced directive with a goal to honor and review annually and upon significant change in condition. Interventions included: ensuring the advanced directive was discussed with resident and/or RP and appropriate paperwork obtained. Record review of Resident #3's discharge notice reflected the resident was issued the notice on 01/23/26 for non-payment of services rendered with a discharge date of 02/21/26. Record review of a document from Texas HHS regarding Resident #3's fair hearing results, dated 05/08/26, reflected that the nursing facility did not provide evidence to determine if applicable law and polices were followed when issuing the discharge notice so the action was reversed during a fair hearing that was conducted on 03/26/26. The nursing facility was instructed to rescind the discharge notice of 01/23/26. Record review of Resident #3's progress notes, dated 03/29/26 by RN A, reflected the following: [An aide] alerted [RN A] to [Resident #3] change in condition. Upon immediate assessment [Resident #3] noted to have rapid, loud gurgling respiration and was nonresponsive to physical stimuli. Immediate vital signs were obtained. Initial:67/50, HR 123, RR 45. Repeat: 70/45 HR 145. RR 32. [Resident #3] Full code verified. 911 activated immediately. [RN A] remained at bedside to assess and monitor [Resident #3's] condition. crash cart positioned at bedside. [MD] notified at [8:50 a.m.] of [Resident #3's] condition and confirmed to 911 out via emergency response. EMS arrived on sight on [8:55 a.m.]. Verbal report given to EMS personnel. EMS verbalized [Resident #3] would be sent to [local hospital]. [ADON] notified at [8:58 a.m.]. In an interview on 06/17/26 at 11:13 a.m., the Administrator stated Resident #3 was sent to the hospital in March 2026 where she remained for a while before being transferred to an LTAC hospital. The Administrator stated Resident #3 was issued a discharge notice on 01/23/26 for non-payment and was at the hospital when a decision was made on the appeal. The Administrator stated the facility received a referral from the LTAC when Resident #3 was ready to be discharged , and they informed the resident's family that she could return if they provided payment towards the balance. The Administrator stated there was a toxic dynamic between Resident #3's family, and they had a hard time agreeing on the resident's care. The Administrator stated after having a conversation with the family about Resident #3's balance there was no further communication. An attempted interview on 06/17/26 at 11:35 a.m. with Resident #3's RP was unsuccessful due to no response to call. This surveyor left callback information on the voicemail. In an interview on 06/17/26 at 12:04 p.m., the Ombudsman stated the facility notified her of Resident #3's discharge notice on 01/23/26, and she filed an appeal. The Ombudsman stated during the appeal process, Resident #3 was transferred to the hospital, and reportedly was not expected to survive, but the resident did. The Ombudsman stated she proceeded with the appeal process and Resident #3 won. However, the facility reported that the resident would not be returning to the facility, so she closed the case. The Ombudsman stated she was unaware that the LTAC attempted (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to send Resident #3 back to the facility and they refused her. In an interview on 06/17/26 at 3:52 p.m., the Administrator stated Resident #3's appeal was filed timely. He stated, to his knowledge, there was a hearing scheduled around February 2026. However, the hearing decision had not been issued prior to the resident's discharge from the hospital. The Administrator stated the facility did not deny Resident #3's return to the facility, but they did require payment first. The Administrator stated he could not state the risk of not allowing a resident to return to the facility in this case. Review of the facility's policy titled Discharge/Transfer Policy, review date on 04/24/24, reflected in part the following: Policy: The resident will be discharged /transferred (home/another entity) by order of his/her attending physician in accordance with standard practice guidelines.Procedure:.E. Involuntary: 1) A resident may be discharged involuntarily for the following reasons:c. Resident has refused to pay their bill after reasonable and appropriate notice to pay or to have paid under Medicare or Medicaid 2) In order to process an involuntary discharge, the Community designee will: a. Develop a safe discharge plan, including but not limited to securing an alternate location, and will have the plan approved by the resident's physician.b. Obtain a physician's order for the discharge.c. Complete the state's Notice of Transfer/Discharge and forward via hand delivery to the resident and/or via certified mail/return receipt requested to the resident's legal representative or interested family member. Where required by law, a copy will also be sent to the state's OmbudsmanThe facility's Discharge/Transfer policy did not address appeals and discharge reversals.