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	01/30/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one of two residents (Resident #38) reviewed for quality of care The facility failed to ensure LVN F and CNA J used a gait belt when transferring Resident #38 from her wheelchair to bed on 01/28/25. These failures could place residents at risk for discomfort, pain, falls, injuries, and skin tears. Findings included: Record review of Resident #38's quarterly MDS assessment, dated 01/14/25 reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #38 was severe cognitively impaired with a BIMs of 06. He had limited range of motion of both lower extremities, required total assistance with transfer from chair to bed/bed to chair. stroke, non-traumatic brain dysfunction, progressive Neurological Conditions, neurological Conditions, amputation, hip and knee replacement and fractures and multiple traumas. Review of Resident #38's care plan revised on 10/23/24 reflected, Resident #38 at risk for fall related to actual fall, history of Parkinson disease and fall risk score of 7-18. Goal, Resident at Risk for Falls resident safety will be maintained over the next 90 days, intervention, Assess for potential fall-related injury prevention, looking at circumstances, location, medication, new or worsening medical problems . make sure that staff members are aware that resident is at high risk for falls . Review of Resident #38's activities of daily living care on 01/28/25 reflected the resident required a gait belt during transfer. In an observation on 01/28/25 at 10:37 AM, revealed Resident #38 was in the wheelchair and a sling on the chair. Resident stated he wanted to be assisted to get to bed, he stated he had been waiting for a while to get in bed. LVN F was on the hallway and was made aware the resident wanted to go to bed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 01/28/25 at 10:42 AM, revealed LVN F and CNA enter Resident #38's room. Upon entering the room, CNA J was observed placing Resident #38 in bed without use of a gait belt or Hoyer lift. In an interview on 01/28/25 at 10:47 AM, LVN F stated if there were two females assisting the resident to bed they will use the Hoyer lift, but if there was a male staff, they were able to transfer the resident without the Hoyer lift. LVN F then stated they were supposed to use the gait belt if they did not use the Hoyer, but they did not have a gait belt with them at the time of the transfer. LVN F stated CNA J picked the resident up from the chair and placed him in bed. LVN F stated the transfer was not appropriate because can J was supposed to use a gait belt and two persons during the transfer. LVN F stated failure to use a gait belt during transfer placed the resident at risk for fall, discomfort and fracture. In an interview on 01/28/25 at 10:52 AM, CNA J stated the resident was able to hold onto him and he was able to transfer the resident and he did not use the gait belt or the Hoyer lift. CNA J stated he was supposed to use the gait belt, but he did not have the gait belt at the time of the transfer. CNA J stated there were gait belts in the storage that he could have used to transfer. CNA J stated failure to use the gait belt during transfer placed a resident at risk for fall. In an interview on 01/30/25 at 11:52 AM, the DON stated Resident #38 used a gait belt with transfer because of the contracture he was not able to use the Hoyer lift. The DON stated she expected the staff to use the gait belt per the care plan during transfer. The DON stated failure of the staff to use the gait belt during transfer placed the resident at risk for fall or if handled under his arms could cause dislocation. Review of the facility policy revised 06/19/2023, titled ADL Care - Transfer Techniques reflected, Staff will provide safe and effective transfer techniques for residents in accordance to standard practice guidelines.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of two residents (Resident #39) reviewed for feeding tubes. 1. The facility failed to ensure LVN F flushed Resident #39's feeding tube by gravity and not by pushing water by the plunger during medication administration. 2. The facility failed to ensure LVN F checked Resident #39's feeding tube placement and residual when starting a feeding. These failures could affect residents by placing them at risk of abdominal discomfort and obstruction of the G-tube. Findings included: Review of Resident #39's face sheet dated 01/29/25 revealed, the resident was a 69- year old female, admitted to the facility on [DATE]. Her diagnoses include chronic obstructive pulmonary disease, type 2 diabetes, anemia, and stage 4 pressure ulcer to the sacrum. Review of Resident #39's quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 04 indicating severe cognitive impairment. Resident required assistance with activities of daily living. Resident #39 had a feeding tube and received 25 -50% of total calories. Review of Resident #39's care plan revised 01/15/25 reflected, altered nutritional status, goal, resident will have no sign and symptoms of aspiration, intervention, monitor tolerance of tube feeding. Observation on 01/28/25 at 01:45 PM, revealed Resident #39 was in the wheelchair. LVN F entered the resident's room with a bottle of feeding and stated she was going to re-start the resident's feeding. LVN F then proceeded to connect the feeding tube and started the feeding without checking placement or residual. In an interview on 01/28/25 at 01:52 PM, LVN F stated she was supposed to check for placement and residual, but she forgot. LVN F stated she was supposed to check for placement and residual to make sure the feeding tube was at the right place and check for residual to make sure the resident did not have too much in her stomach. LVN F stated failure to check placement and residual could have negative effects on the resident like aspiration. In an observation on 01/29/25 at 11:05 AM, revealed LVN F entered Resident #39's and positioned the resident and then paused the feeding tube. LVN F then proceeded to flush the feeding tube by pushing the water with the plunger. LVN F then administered the medication with gravity and flushed after medication administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/29/25 at 11:18 AM, LVN F stated she was supposed to let water flow by gravity, but she forgot. LVN F stated she was not supposed to push the water with the plunger. LVN F stated she was supposed to let water flow by gravity to prevent discomfort. In an interview on 01/30/25 at 11:44 AM, the DON stated the staff was supposed to follow the physician orders. The DON stated LVN F was not supposed to push water through the g-tube, she was supposed to administer the water flow by gravity because it would cause discomfort and could cause nausea to the resident. The DON stated she expected LVN F to check the feeding tube placement and residual before starting the feeding to make sure the resident was digesting well, and she was not retaining the feeding in the stomach which could lead to aspiration . Review of the facility policy dated 05/19/23, titled enteral nutrition for closed system nasogastric, nasointestinal, jejunal and gastric feeding tubes, reflected, Enteral nutrition therapy will be performed in a safe manner by qualified licensed nurses according to standard practice guidelines.6. Verify placement by aspiration of the stomach contents, except jejuna and nasointestinal feeding tubes. 7. Check for bowel sounds and gastric residual amount.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5%, for 39 medication administration opportunities with 6 errors resulting in a 15% medication error rate, for 3 of 6 residents (Residents #66, #42, & #00) reviewed for medication administration. 1. RN G failed to administerAcetaminophen 500 mg per physician order, medication was administered at 09:30 and the medication was scheduled at to be administered at 12 pm. 2. RN G failed to administer Resident #42 Olmesartan during medication administration that was scheduled at 8 am. 3. RN G failed to administer Resident #00 medication per physician orders, medications scheduled at 8 am was administered at 11:15 am This deficient practice placed residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: Record review of Resident #66's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnoses which included fracture of shaft of left femur, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, Muscle weakness (generalized), abnormalities of gait and mobility and disorders of muscle. Record review of Resident #66's quarterly assessment MDS dated [DATE] revealed Resident #66 had a BIMS score of 11, indicating mild cognitive impairment. Record review of Resident #66's care plan dated 11/07/24 revealed, acute pain, goal, Resident will report or demonstrate relief of pain every day over the next 90 days, intervention, Administer pain medications as ordered. Record review of Resident #66's physicians orders dated January 2024 revealed the physician prescribed for Resident #66 to receive the following medications : MiraLAX 17 gm by mouth 1 time a day, at 8am Tylenol extra strength 500 mg every 6 hours, at 6am, 12p, 6p Sucralfate 1 gm 1 tablet, at 6:30am, 11:30am, 4:30pm, 8pm, 12am Buspirone 15 mg 1 tablet, at 8am Gabapentin 600 mg 1 tablet, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol 50 mg, at 8am and 8pm Nifedipine 90 mg, at 8am Prilosec 20 mg, at 7 am Observation on 01/28/25 at 09:30 AM, revealed RN G administered the following medications to Resident #66; Gabapentin 600 mg 1 tablet. Sucralfate 1 gm 1 tablet Buspirone HCL 15 mg 1 tablet Acetaminophen 500 mg 1 tablet MiraLAX 17 gm Metoprolol and Nifedipine - Held due to low blood pressure. Prilosec 20 mg - not available Review of Resident #66's medication administration record dated 01/30/25 reflected Acetaminophen 500 mg was scheduled to be administered at 12pm. 2. Record review of Resident #42's admission record dated 01/30/25 revealed an admitted [DATE] with diagnoses which included fracture of left lower leg, subsequent encounter for closed fracture with routine healing, hypothyroidism, gastro-esophageal reflux disease without esophagitis, vitamin deficiency, depression, unspecified, abnormalities of gait and mobility, unsteadiness on feet and weakness. Record review of Resident #42's annual assessment MDS dated [DATE] revealed Resident #42 had a BIMS score not filled ((resident was unable to complete Brief Interview for Mental Status). Record review of Resident #42's physicians orders dated January 2024 revealed the physician prescribed Resident #42 to receive the following medications : Escitalopram 10 mg (take with 7.5 mg) one time, at 8am Metoprolol ER 100 mg (Do not crush) one time, at 8am Vitamin C 500 mg two times daily, 8am and 8pm Tramadol 50 mg one time daily, at 8am Optimum (eye support) two times daily, at 8am and 8pm AZO cranberry 1 capsule two times daily, at 8am and 8pm (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vitamin D 25 mcg (1000 iu) 2 tabs Vitamin B-12 500 mcg one time, at 8am Daily multi-vitamin one time, at 8am Potassium chloride 10 milliequivalent, at 8am Olmesartan 40 mg one time, 8am Observation on 01/28/25 at 09:59 AM revealed RN G administered the following medications to Resident #42. Escitalopram 10 mg 1 tablet Metoprolol ER 100 mg (Do not crush) 1 tablet. Vitamin C 500 mg 1 tablet Tramadol 50 mg 1 tablet Optimum (eye support) 1 tablet AZO cranberry 1 capsule Vitamin D 25 mcg (1000 iu) 2 tablet Vitamin B-12 500 mcg 1 tablet Daily multi-vitamin 1 tablet Escitalopram 5 mg 1 tablet Potassium chloride not available Review of Resident #42's medication administration record dated 01/30/25 reflected RN G failed to administer Olmesartan 40mg that was scheduled at 8am. Record review of Resident #00's admission record dated 01/29/25 revealed an admitted [DATE] with diagnoses which included abnormalities of gait and mobility, presence of left artificial hip joint, hyperlipidemia, chronic obstructive pulmonary disease, major depressive disorder, Type 2 diabetes mellitus, hypertension, and muscle spasm of back. Record review of Resident #00 dated 01/27/25 reflected it was not completed because Resident #00 was recently admitted to the facility. Record review of Resident #00's physician order review dated January 2024 revealed physician prescribed the following medications : (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Baclofen 10 mg 1 1/2 tablets three times daily, at 8am, 12pm, 8pm Lisinopril 10 mg 1 tablet, at 8am Gabapentin 400 mg 1 capsule three times daily, at 8am, 12pm, 8pm Meloxicam 15 mg 1 tablet, at 8am Observation on 01/28/25 at 11:15 AM revealed RN G administered the following medication to Resident #00: Baclofen 10 mg - 1 1/2 tablets. Lisinopril 10 mg 1 tablet Gabapentin 400 mg 1 capsule Meloxicam 15 mg 1 tablet Record review of Resident #00 medication administration record dated 01/30/25 reflected medications, Baclofen 10 mg - 11/2 tablet, Lisinopril 10 mg 1 tablet, Gabapentin 400 mg 1 capsule and Meloxicam 15 mg 1 tablet were scheduled to be administered at 8am. In an interview on 01/30/25 at 10:25 AM, with RN G she confirmed she administered the medications late and she did not follow the medication guidelines of one hour before and one after. RN G stated she was late to administer medications because she had a lot of residents to administer medications to . RN G stated she was supposed to follow the 5 rights of medication administration: dose, patient, time, dose and route. RN G stated medications administered not at the right time could be ineffective and if there was another dose scheduled at noon could lead to an overdose to the residents. RN G stated she was supposed to follow the physician orders and administer all medications . In an interview on 01/30/25 at 11:59 AM, the DON stated RN G was supposed to be given medication within the time frame which is one hour before and one hour after. The DON stated the residents were to be administered all the scheduled medications, and if not available the staff were to notify the resident's primary care provider. The DON stated the risk for the resident for being given medications late could cause negative effects to the resident like the medications being ineffective. The DON stated the facility completed in-service on June, 2024 on medication administration . Review of the facility policy dated 2007 and titled Medication Administration reflected, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so.14. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review, the facility failed to ensure each resident received food that accommodated their preferences for 3 (Resident #40, Confidential #1 and #2) of 8 residents reviewed for dietary services . 1. The facility failed to honor Resident #40's preferences and recommendations as indicated on his menu . 2. The facility failed to honor the preferences of Confidential Resident #1 as indicated on their menu selections. 3. The facility failed to honor Confidential Resident #2's wishes and continued to send the wrong food items on their tray. This failure could place residents at risk for not having their choices and food preferences accommodated, possible weight loss and a diminished quality of life. Findings included: 1. Record review of Resident #40's Face Sheet dated 1/29/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #40's Annual MDS assessment dated [DATE] reflected he had a BIMS score of 13 indicatedhe was cognitively intact. His diagnoses included coronary artery disease, diabetes mellitus, stroke, paraplegia, anxiety, and depression. He had venous and arterial ulcers present. Record review of Resident #40's Consolidated Orders dated 1/30/25 reflected: DIET: thin liquids; RCS; Large Portions only protein (Meat/eggs). During an observation and interview on 1/28/25 at 10:40 AM, Resident #40 was observed in his room, in bed. He had a small refrigerator and multiple food items and snacks on his bedside table, nightstand and dresser. When discussing meals served at the facility, he stated no one reads the meal tickets, I circle what I want and get something else. The ticket will say 'pork chop' and a hamburger comes. He stated he had spoken with someone in the kitchen twice about it and they will say they don't have this or that. He stated he stopped complaining about it and his family brought him food from a nearby grocery store. Resident #40 stated the kitchen provided menu tickets so they could circle the items they wanted but it usually did not do any good. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/28/25 at 1:14 PM, Resident #40 was observed in bed with his lunch tray on his bedside table. The ticket on his tray reflected he had circled the following items as his choices: Baked pork chop, German potato salad, tossed salad, crispy rice dessert bar and tea. Notes: Large portion protein (meat/eggs) only. He pointed at his plate which had only a bone from one pork chop on it. He stated he didn't know what happened to the potato salad. The rest of the plate was clean. He had a small, tossed salad in a separate bowl and a krispy rice dessert. He stated he was supposed to get double protein and only got one pork chop. No potato salad was provided. A bowl of ravioli was observed next to his tray. Resident #40 stated it was not uncommon and happened a lot. He stated he did not bother complaining about it anymore unless he was really hungry for it. He stated he had asked a staff member to heat up some ravioli from his personal stock for him and they did. 2. During an observation and interview on 1/28/25, Confidential Resident #1 was observed sitting up in bed, was awake and alert. A lunch tray was delivered, and the resident stated they did not like the food very much. They stated the meal tickets did not always match the meal provided or have what they had circled as a preference. Their tray ticket reflected they had selected a pork chop, German potato salad, dinner role, crispy rice dessert, soup of the day and a shake. Dislikes: pasta, rice, salad . There was no potato salad on the plate and there was a side salad on the tray. Confidential Resident #1 stated they had complained before felt the staff did not understand so they dropped it. Another observation and interview with Confidential Resident #1 on 1/29/25 revealed they were sitting up in bed with the lunch tray situated in front of them The selections on the tray ticket reflected they had circled Creamy mushroom chicken, squash medley, peach cobbler, and dinner roll. The ticket still reflected, Dislikes: Pasta, rice, salad. Observation of the meal revealed a chicken breast with gravy, squash, pasta, and cobbler. The resident stated they had already eaten the dinner roll but did not have an appetite for anything else. During an interview on 1/30/25 at 8:10 AM, ADON A stated the hall meal tickets and trays were checked first in the kitchen then again on the halls by the charge nurses and CNAs. She stated the charge nurses were responsible for ensuring the residents received the correct meal. 3. During an observation and interview on 1/30/25, Confidential Resident #2 was observed sitting up in bed. Their breakfast tray was delivered and set up in front of them. They stated the food was ok and breakfast was correct, but sometimes got different food than what they ordered. They stated they complained about it a few times but did not say much about it anymore. Confidential Resident #2 stated the food was beginning to taste better and they were still getting the wrong trays and hoped that would improve soon. During an interview on 1/30/25 at 8:58 AM, LVN H stated the charge nurses and CNAs were responsible for checking the meal trays to their tickets and they were sometimes incorrect. She stated the main focus was to ensure they received the correct texture and liquid type such as mechanical soft and thin liquids. She stated she could not recall hearing anyone complain about their meals. LVN H stated she did not recall noticing no trays had potatoes on 1/28/25 or that Resident #40 had not received his extra protein. She stated the risk to residents was they may not get what they requested and not eat. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 9:00 AM, CNA B stated she had not noticed Resident #40 was missing his potatoes and extra meat on 1/28/25. She stated sometimes the kitchen got the orders wrong and she would go and tell them. She stated they were sometimes rude to her and would not would not always fix it. I've gone several times and they have been rude, I told [DON]. Go ask Resident #40, his is wrong a lot. Sometimes I heat his food for him if he does not want his tray. Yesterday he sent his tray back, it was ok, but he just did not want it and wanted his own food. She stated the risk was upsetting the residents. During an interview on 1/30/25 at 9:10 AM, LVN F stated the nurses checked the trays for accuracy when they come to the hall. She stated a lot of times, residents write in special requests and the kitchen may not have those things available. LVN F stated, We definitely focus on textures, but sometimes preferences are missed. She stated she did not recall hearing complaints from residents, and they could go to the kitchen if they did. She denied having experienced kitchen staff being rude to her. She stated the risk was making residents unhappy. During an interview on 1/30/25 at 10:26 AM, the DON stated the kitchen staff were required to check the meal tickets before they left the kitchen, and the nurses were responsible for checking the trays before passing them to the rooms. She stated they were to check to ensure the diet was the correct texture, correct order and followed the resident's preferences. The DON stated CNAs had previously reported to her that kitchen staff were rude to them if they went to request corrections. She was uncertain when she had received the report. She stated she had discussed the matter to the Dietary Manager, but he was out today. She stated she would follow-up with him when he returned. The DON stated the risks to residents included weight loss due to not eating, not receiving benefits of special diets, and experiencing feelings of not being heard. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interviews on 1/30/25 at 12:17 PM, kitchen staff were observed preparing trays in the kitchen. They were reading resident tickets and plating food. The Regional Dietary Consultant was monitoring the staff and stated she was helping that day because the Dietary Manager was out. The Regional Dietary Consultant stated she was generally at the building 1 to 2 times a week and was there on 1/28/25. She stated she was unaware of any issues with the lunch meal on 1/28/25. She stated she had just learned that week there had been complaints from the residents about the trays. She stated she had never heard anything about the staff being rude to nursing staff. When the Regional Dietary Consultant was informed about the lack of potatoes and extra protein portions for Resident #40, she retrieved his ticket and located the note reflecting Large Portion Protein (Meat/eggs) only was located at the bottom of the ticket. She stated it was possible the staff had overlooked it. The Regional Dietary Consultant stated the kitchen staff and nursing staff were responsible for checking the meal tickets to the trays. She stated, ideally, if something was missing, they would come and let them know. She stated the risk to residents receiving the wrong food or not having their preferences honored was it could make them sad and feel not heard and some residents could experience weight loss. [NAME] I joined the conversation and stated she had been there all week. She stated she had made the decision to replace the German potato salad on 1/28/24 with macaroni salad because she had a lot of left over macaroni and did not want it to go to waste. She stated she was allowed to make occasional substitutions and the information was usually communicated to the nursing staff so they could let the residents know. She could not recall whether the information had been communicated that day. She stated she was unsure why Resident #40's tray had no macaroni or extra protein. [NAME] I denied ever hearing the kitchen staff being rude to nursing staff. She stated they believed the residents were sometimes confused filling out their tickets and she believed they needed assistance. She stated some residents would circle everything on the ticket leading to a lot of food waste and she believed there were communication issues. The Regional Dietary Consultant reviewed a stack of menu tickets and stated she believed they could improve the layout to make it easier for the residents and staff to read. She stated there had been ongoing efforts to improve the dietary service and communication between staff and residents. Record review of the facility's undated policy, Selective Menus, reflected: Selective menus will be provided to all residents in accordance with their prescribed diet. Procedure: I. Selective menus are provided to all residents who choose to make their own menu selections. Assistance from family or staff is encouraged for those residents who cannot select their own menus. 2. The select menu will identify the resident's name, room number, allergies, and diet. 3. Facility staff may assist in the delivery of menus and in the menu selection process as deemed necessary. 4. Facility staff will guide/counsel residents, if needed, on appropriate choices for their therapeutic diets and will document accordingly in the medical record. 5. If a resident does not make menu selections, the default menu will be the standard facility menu. Known preferences and allergies will be honored during the process.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47161 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. 1. The facility failed to ensure food in the facility's dry storage, refrigerator, and freezer areas were labeled and dated according to guidelines. 2. The facility failed to seal open items in plastic bags in the dry storage pantry, refrigerator, and freezer areas. 3. The facility failed to ensure that expired items in the dry storage pantry, refrigerator and freezer areas were removed. These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other air-borne illnesses. Findings Included: Observation of the kitchen during the brief initial tour of the kitchen on [DATE] at 9:15 AM, revealed the following: Dry storage area *One open clear container with 4 bags of vanilla wafers with an expiration date, [DATE], *Nine unopened packages of La Banderita Flour Tortillas with an expiration date of [DATE], *One Ziplock bag with opened tortillas labeled with expiration date ,d+[DATE], *One box labeled Block & Barrel with an unsealed blue bag inside with pretzel sticks, *One bag of Sysco Instant Vanilla Pudding Mix; ,d+[DATE] of the package remained tied in a knot in an unsealed bag, *One Hershey Cocoa Mix unlabeled in a plastic white bag enclosed by Ziploc bag that has a hole in the bag, *One clear container with red lid labeled Cocoa partially open, *One Brownie mix opened with a plastic tie knot, *One 28oz dented can of [NAME] Red Pimentos Diced on the shelf with 5 other undented cans, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* One dented can of Musselman's Sliced Apples on the shelf with undented cans, *One 6.6lb dented can of La [NAME] Enchilada Sauce on the shelf with undented cans, * One 6lb dented can of Sysco Spaghetti Sauce on the shelf with undented cans, *One 6.6lb dented can of [NAME] Monte Lite Dices Pears on the shelf with 2 undented cans in a pallet, *One 50oz dented can of Campbell's Vegetable Stock Soup on the shelf, *One 5 lb. jar of Sysco creamy peanut butter that was unsealed, and * Black & Barrel Potato Chips not labeled in a sealed Ziploc bag. Refrigerator area *One Ziploc bag of shredded cheese not dated, * One unsealed clear plastic container of Grape jelly, *One pan labeled Mac Salad unsealed with a spoon in it, *One bag of opened unsealed carrots, * One gallon of 2 % milk with an expiration date of [DATE], opened and not sealed with milk spoiled around the cap in a black crate with 3 unopened gallons of 2 % milk, *One 5 gallon container of Best Maid Hamburger Sliced Pickles unsealed, *One 5lb [NAME] Deli Salad unsealed, and *One 25lb Chef Grade Hard Cooked Peeled Eggs in an unsealed container. Prep Area: *One clear container with a blue lid labeled brown sugar dated ,d+[DATE] unsealed. The containers of loose sugar, rice and flour had lids that were not labeled: - The white container with the rice had a scoop inside of the container. - The white container with the flour had a scoop inside of the container. - The white container with the loose sugar had a scoop inside of the container. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Regional Dietary Manager on [DATE] at 10:45 AM, stated all staff are responsible for ensuring items in the kitchen's dry pantry, refrigerator, and freezer areas are not expired and unsealed. She stated she would audit everything in the kitchen to ensure there were not any unopened and expired items in the dry pantry, refrigerator and freezer areas. She stated she would throw away all expired items in the kitchen and the unsealed items as well. She stated her expectation was for staff to throw away any items that are expired or opened in the kitchen's dry pantry, refrigerator and freezer areas and notify herself or the Dietary Aide of what they found. She stated staff have received several in-services relating to food preparation, store, labeling and immediately removing expired items. She stated staff have been trained and educated when they are restocking to place the items already on the shelf in the front and the new items behind the items that were already shelved. She stated she would throw away the expired items in the kitchen and retrain and reeducate the staff via in-service trainings. In an interview with [NAME] B on [DATE] at 11:30 AM, she stated that she had been employed at the facility for 5 years. She stated that she was unaware that there were expired and unsealed items in the dry storage, refrigerator, and freezer areas. She stated that all the staff were responsible for storing the items on the shelf and checking the expiration dates on everything in the kitchen. She stated that she had taken in-service trainings on food preparation and storage and her last in-service training was two weeks ago. She stated that if a staff member sees an item(s) that are expired, the staff member was to throw the item away in the trash can and then inform the Dietary Manager or Dietary Aide what they threw away. She stated that everything in the dry storage, freezer and refrigerator should be labeled and dated. [NAME] B stated that if someone ingested food that had been cross-contaminated, there was a risk that someone could get an airborne illness and potentially cause harm and sickness. She stated that with food in the dry pantry, refrigerator and freezer areas being unsealed and expired items can cause anyone who ingests the food to have an airborne illness an become sick and cause them harm. In an interview with the Dietary Aide on [DATE] at 11:48 PM, she stated that she had been employed at the facility for 9 months. She stated that she was unaware that there were expired and unsealed items in the dry storage and freezer areas. She advised that all the staff were responsible for storing the items on the shelf and checking the expiration dates on everything in the kitchen. She stated that her expectations for all staff in the kitchen is to use the First In, First Out Method, which means that kitchen staff should label the food with the dates they store them, and when staff are restocking the shelves, they are to put the older foods in front or on top so they can be used first. She stated that this system allowed the kitchen staff to find the food quickly and use it more efficiently. She stated the Dietary Manager In-Services staff on food storage, labeling and dating and removing expired items from the shelves in the dry pantry, freezer, and refrigerator areas. She stated that there are risks of airborne illness anytime someone that ingest food items from the kitchen any items that have not been label and stored properly. Record review of the facility's policy titled Food Storage dated, 2018 reflected, Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination, Procedure: 1. Storeroom: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The storeroom is well-ventilated and well lit. Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened. Chemicals are stored in an area away from food. Scoops and storage bins are routinely washed and sanitized. All stock is rotated with each new order received using a First In, First Out system. Food is stored a minimum of 6 inches above the floor and 18 inches from the ceiling on clean racks or shelves, and is protected from splash, overhead pipes, or other contamination. Emergency supplies of food and disposables are stored in a designated area of the storeroom. 2. Refrigerator: Every refrigerator is equipped with an internal thermometer. Temperatures for refrigerators are at or below 40 degrees Fahrenheit. Temperatures are checked at least twice daily. (See Refrigerator/Freezer Temperature Log). All perishable food is refrigerated immediately to ensure nutritive value and quality. All foods are stored to allow air circulation. Opened containers of thickened liquids are stored in the refrigerator with both open and discard dates. Each nursing unit with a refrigerator/freezer unit is checked daily for appropriate temperatures. Ready to eat foods are stored above raw meat, poultry, seafood, and eggs. All foods are covered, labeled and dated. Defrosting meat, eggs and milk shakes are labeled with date pulled for thawing. All foods are stored off the floor. 3. Freezer: Every freezer is equipped with an internal thermometer. Temperatures are checked and logged at least twice daily. Frozen items are thawed in a refrigerator for 24 to 72 hours. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Foods are covered, labeled and dated. Any item out of the original case must be properly secured and labeled. All foods are stored to allow air circulation. All foods are stored off the floor. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S , d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].

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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** 28637 Based on observation, interviews, and record review the facility failed to establish and 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 four (Resident #39, Resident #40, Resident #34, and Resident #52) of nine residents observed for infection control. 1. ADON A failed to perform hand hygiene between cleaning Resident #39's wounds and applying the clean dressings. 2. ADON A failed to perform hand hygiene and change her gloves when moving between wound sites during wound care for Resident #40. 3. CNA B failed to implement enhanced barrier precautions and don a gown while providing incontinent care to Resident #34. 4. CNA C and CNA D failed to implement enhanced barrier precautions and don a gown while transferring and providing incontinent care to Resident #52. These failures placed residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Review of Resident #39's face sheet dated 01/29/25 revealed, the resident was a 69- years old female. She was admitted to the facility on [DATE]. She was admitted with, chronic obstructive pulmonary disease, type 2 diabetes, anemia, and stage 4 pressure ulcer to the sacrum. Review of Resident #39's quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 04 indicating severe cognitive impairment. Resident required assistance with activities of daily living. Resident #39 had a pressure ulcer. Review of Resident #39's care plan revised 01/15/25 reflected, Resident #39 was at risk/actual skin breakdown as evidence by pressure ulcer. Goal, Measures will be taken to prevent skin breakdown over the next 90 days and Open area will be healed over the next 90 days. Intervention, Position resident properly; use pressure-reducing or pressure-relieving devices (e.g., pillows, positioning wedges, and alternating pressure mattress). Treatments and dressings as ordered per physician. Observation on 01/29/25 at 11:20 AM, revealed ADON A completing wound care to Resident #39. ADON A gathered the supplies and positioned the resident on the side. ADON A then took off the dirty dressing and took off the gloves and completed hand hygiene. ADON A gloved and cleaned Resident #39's wound with gauze and normal saline and then proceeded to applying the clean dressing, labelled, and dated. (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 01/29/25 at 02:33 PM, ADON A stated she missed to complete hand hygiene and change gloves after cleaning the resident's wounds. ADON A stated she was supposed to complete hand hygiene and change gloves after cleaning the resident's wound and not touching the clean dressing with the dirty gloves she used to clean the resident's wound. ADON A stated she was supposed to complete hand hygiene due to infection control. 2. Record review of Resident #40's Face Sheet dated 1/29/25 a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #40's Annual MDS assessment dated [DATE] reflected he had a BIMS score of 13 indicating he was cognitively intact. His diagnoses included coronary artery disease, diabetes mellitus, stroke, paraplegia, anxiety, and depression. He had venous and arterial ulcers present. Record review of Resident #40's Care Plan reflected: An entry dated 1/15/25 At risk for/actual skin breakdown related to: history of rash/dermatitis. Interventions included, treatments and dressings as ordered per physician. Record review of Resident #40's Consolidated Orders dated 1/30/25 reflected: Cleanse bilateral lower legs with NS, pat dry, apply triamcinolone 0.1% cream (steroid) to entire legs and feet, apply calcium alginate, apply ABD pads and wrap with kerlix (gauze wrap) and ace wrap. During an observation and interview on 1/29/25 at 11:20 AM, Resident #40 was observed in bed. His dressings had been removed from both his legs. His lower legs were swollen and pink. There were scattered open areas and scabbed areas on both. His left upper leg was swollen with large pink areas. ADON A and CNA B entered to provide care. Both staff washed their hands and donned gloves and gowns. ADON A and Resident #40 discussed the history of his wounds stating he had developed swelling and bleeding and was diagnosed with venous insufficiency. Resident #40 stated he was told he had decreased blood flow from his legs to his heart. He had an ablation procedure (using heat or chemicals to close damaged veins) then developed large blisters on both legs afterward. The blisters had since resolved leaving the wounds on his legs. ADON A proceeded to clean both legs using normal saline soaked gauze. She replaced her gloves and sanitized her hands between the legs and after cleaning. She then applied the triamcinolone cream and calcium alginate to both legs using the same gloves as she switched between legs. She changed her gloves and sanitized her hands then placed the clean dressings to both legs, again using the same gloves on both legs. ADON A secured the trash, both staff doffed their PPE. During an interview on 1/29/25 at 2:30 PM, ADON A stated she should have treated Resident #40's legs separately, changed her gloves and sanitized her hands between the sites. She stated the risk was spread of infection. 3. Record review of Resident #34's Face Sheet dated 1/30/25 reflected he was an [AGE] year-old male readmitted to the facility on [DATE]. Record review of Resident #34's Quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 11 indicating moderately impaired cognition. His diagnoses included, obstructive uropathy (condition where urine cannot pass through the urinary tract); diabetes mellitus, anxiety disorder, and depression. He had an indwelling catheter (tube inserted into the bladder to drain urine) and was receiving IV medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #34's Care Plan reflected: An entry dated 12/18/24: Infection Control: Enhanced Barrier Precautions. Goal: Prevent Spread of Multidrug resistant Organisms. Interventions: Enhanced Barrier Precautions: gown and glove use during high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, wound care, and any skin opening requiring a dressing. Record review of Resident #34's progress notes reflected a note from an Infectious Disease specialist dated 1/23/25. The note reflected he was referred to the specialist by his attending physician for diagnoses including UTI ESBL (a type of infection resistant to antibiotics), and Flu type A. The assessment/plan reflected Resident #34 had chronic urinary tract infections and he was to receive IV antibiotics and isolation for ESBL. Record review of Resident #34's Consolidated Orders dated 1/30/25 reflected: An order dated 12/18/24 for Enhances Barrier Precautions, reason: Foley (indwelling urinary catheter). An order dated 1/17/25 for Meropenem (antibiotic) 500 mg intravenous solution every 8 hours for 14 days. 500 mg/100 ml 0.9% sodium chloride intravenous. Dx: urinary tract infection. During an observation and interview on 1/29/25 at 11:10 AM, Resident #34 was observed lying in bed. There was a container of PPE including gowns and gloves located outside his room. He had a sign on his door indicating he was on contact precautions. He had a catheter in place draining urine and was receiving an IV infusion via a midline intravenous line on his left upper arm. CNA B was observed providing incontinent care to Resident #34. She was wearing a mask and gloves but was not wearing a gown. After providing care, she was observed draining his urinary catheter into a urinal which she then flushed into the toilet. She rinsed the urinal and washed her hands and exited the room. When asked about the PPE outside his room, CNA B explained Resident #34's name tag was blue indicating he was on enhanced barrier precautions. She stated she realized she should have donned a gown for his care. She stated she had just gone in to check him and noticed he had had a bowel movement. She stated she wanted to get him cleaned up quickly and had failed to don a gown. CNA B stated he was also on contact precautions due to a urinary tract infection. She stated the risk to the resident included the spread of infection. 4. Record review of Resident #52's Face Sheet dated 1/28/25 reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #52's Quarterly MDS Assessment dates 12/11/24 reflected she did not speak and was rarely/never understood. She had severely impaired cognition. She was totally dependent on staff for all ADLs. Her diagnoses included hypertension (high blood pressure), peripheral vascular disease, diabetes mellitus, aphasia following stroke (inability to speak), stroke and seizure disorder. She was fed and provided hydration via feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52's Care Plan reflected: An entry dated 11/26/24: Infection Control: Enhanced Barrier Precautions evidence by enteral feeding and indwelling medical device. Goal: Prevent Spread of Multidrug resistant Organisms. Interventions: Enhanced Barrier Precautions: gown and glove use during high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, wound care, and any skin opening requiring a dressing. An observation and interview on 1/29/25 at 1:57 PM, revealed Resident #52 was observed in her room. Her name tag on her door was blue, indicating she was on Enhanced Barrier Precautions and there was a container with PPE outside her door. She was sitting in her room, in a geri-chair (recliner type chair with wheels), she was awake and did not respond verbally to greeting. Her tube feeding had been disconnected and was hanging on a pole in the corner of her room. CNA C and CNA D entered the room with a mechanical lift. Both washed their hands and donned gloves, neither donned a gown. CNA C and CNA D transferred Resident #52 to bed using the mechanical lift. Both CNAs changed gloves and sanitized their hands. Neither CNA donned a gown. The CNAs provided incontinent care to Resident #52 and changed gloves appropriately during care. Both CNAs washed their hands after care. Once outside the room, the CNAs were asked about Resident #52's blue name tag. CNA D pointed to the PPE and stated, it means to wear that, I should have worn a gown, I blanked out. CNA C stated, I blanked out too, I should have worn a gown. She has a g-tube and is at risk for spread of infection. During an interview on 1/29/25 at 3:00 PM, ADON E stated she had been the Infection Preventionist for the facility for 4 years. She stated she provided infection control in-services for facility staff upon orientation and has monthly trainings related to hand-hygiene, enhanced barrier precautions, and PPE. She stated she expected staff to follow enhanced barrier precautions anytime their scrubs may come into contact with a resident including transfers, emptying catheters, providing incontinent care. She stated residents with indwelling tubes, IV lines, and wounds. ADON E stated they had just had in-service training on 1/27/25 as well as additional training that morning. She stated staff should treat wounds individually and perform hand hygiene when moving between soiled and clean dressings and when moving between wound sites to prevent the spread of infection. She stated using enhanced barrier precautions and wearing gowns provided an extra layer of protection for the residents and staff and the risk of failing to follow enhanced barrier precautions and hand hygiene was the spread of infections between residents. ADON E stated staff were monitored by herself, ADON A, and the DON by training during staff meetings, providing skills fairs and performing staff audits. She stated she regularly performed random observations of staff providing care on all shifts and her goal was to watch 10% of the staff every month. During an interview on 1/30/25 at 10:26 AM, the DON stated she had been informed of the infection control concerns from the ADONs. She stated ADON A should have sanitized her hands and changes gloves during wound care between contact with soiled and clean dressings and when changing wound sites to prevent the spread of infection. She stated the staff should have followed enhanced barrier precautions and worn gowns during care due to the risk of cross contamination. The DON stated ADON E trained the staff all the time including this week and they knew better. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Hand Hygiene for Staff and Residents, dated revised August 2018 reflected: Purpose: To reduce the spread of infection with proper hand hygiene. Policy: Proper hand hygiene technique is completed whenever hand hygiene is indicated. Note: Hand Hygiene is the most important component for preventing the spread of infection. Maintaining clean hands is important for residents/visitors as well as staff .Procedures: 1. Hand hygiene is done: Before: A. Resident contact .G. taking part in a medical or surgical procedure. After: A. Contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B Resident contact. C. contact with contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids or wounds . Record review of the facility's policy, Enhanced Barrier Precautions, dated April 1, 2024 reflected: Policy: Many residents in nursing homes are at increased risk of becoming colonized and developing infections with multi-drug resistant organisms (MDROs). This facility utilizes Enhanced Barrier Precautions (EBP) as a strategy to decrease transmission of CDC-targeted and epidemiologically important MDROs when Contact Precautions do not apply. Procedure: A. Indications: .2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO .b. Chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. c. Indwelling medical devices include central lines .urinary catheters, feeding tubes, and tracheostomies .3. High Contact Resident Care Activities: .c. Transferring. d. Providing Hygiene .f. Changing briefs or assisting with toileting. g. Device care or use: Central line, Urinary catheter, feeding tube, tracheostomy .Definitions: . Enhanced Barrier Precautions: An infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact care activities that provide opportunities for transfer of MDROs to staff hands and clothing . 37193